Nā Shariram Nādhi

My Body is Mine

Sabala & Kranti

What some of our readers and reviewers say...

*'With colourful original drawings of the participants on the cover and a title declaring "**My body is Mine!**", this is much more than a book on health literacy and self help...*

The title has emanated from the participants themselves during their experience of the training. It expresses their right over their bodies and asserts the need for control over their lives. Rather than an individualistic challenge, it speaks of the social realisation that " to bring about a broader change, we have to begin with ourselves." '

***Roopashri Sinha**, Radical Journal of Health, Mumbai*

*'In their book **Na Shariram Nadhi** the authors take us with great openness into their process of guiding the women through discussion, role-playing, and personal explorations into the experience of being women in a class and caste discriminating society.'*

***Sumati Nair**, Women's Global Network for Reproductive Rights, Amsterdam, Netherlands, Europe*

'... sensitivity and gentleness in a rare balance that can be understood by any reader.'

***Shangon Das Gupta**, Voices, Madhyam Communications, Bangalore*

*'I saw **Na Shariram Nadhi** on our bookshelf with its attractive purple cover... went through it and found the language simple and readable, the experiences of the women very moving. Once you start reading it grips you like a novel. Congrats...'*

***April Taylor**, Boston Women's Health Book Collective and Black Women's Health Project, Boston, U.S.A.*

*'**Na Shariram Nadhi** is genuine and fa... and it has inspired me to write up my ow... experiences with teenaged women.'*

***Anu Gupta**, Eklavya, Dewas, Madhya Pradesh*

'The outcome of your work with village women and the definitions of how they see themselves are quite fascinating. A woman's body is part and parcel of a woman's life, and the book portrays a creative method of employing this relationship.'

***Sudha Kothari**, Chaitanya, Pune District, Maharashtra*

'This is the first time I have ever read a training manual from cover to cover - I mean it!'

***Shailaja Kalle**, Betul District, Madhya Pradesh*

'In a culture where sexuality is kept under wraps and women are ashamed to ask for medical help for gynaecological disorders, such training is revolutionary - it reflects the radical changes being made in Indian society by India's small but influential women's movement.'

***Sharmila Joshi**, Women's Feature Service, New Delhi*

'I am very impressed by the work reflected in your book. It is beautifully laid out with clear and evocative illustrations, and it has accurate information presented in a comprehensible manner. But, what has impressed me most is the honest desire to learn and share experientially with other women with whom you began this work, and which comes across so strongly...'

***Radhika Chandiramani**, TARSHI (Talking About Reproductive & Sexual Health Issues), New Delhi:*

*'**My Body is Mine** is an expression of women's lives and bodily integrity beyond illness and childbearing, from their own perspective. I believe it is a first step in women recognising themselves as human beings. It is a fundamental approach for the struggle a... ...iolence and for women's hum...*

...e, Addis Ababa, Ethiopia ..., Durame, Kambatta Dt., ...outhern Ethiopia, Africa)

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edited by Mira Sadgopal

About the Title: *Na Shariram Nadhi ! - My Body is Mine* are words of the participant women in this self-help training. They express their right over their bodies and the need for control over their lives. We cautioned them that, saying it like this, it can be mis-understood as being individualistic. But the women were very clear. They said, *'To bring about a broader change, we have to begin with ourselves.'* The title speaks of our identity and our politics.

About the cover: The drawings on the cover were done by the *sangha* member participants in the training. They convey their perceptions of a woman's body. They reflect dalit and tribal (*lambadi* and *enadi*) styles in parts of Andhra Pradesh.

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Sanjay Pawar

Lay-Out and Type-Setting
Dinanath Manohar

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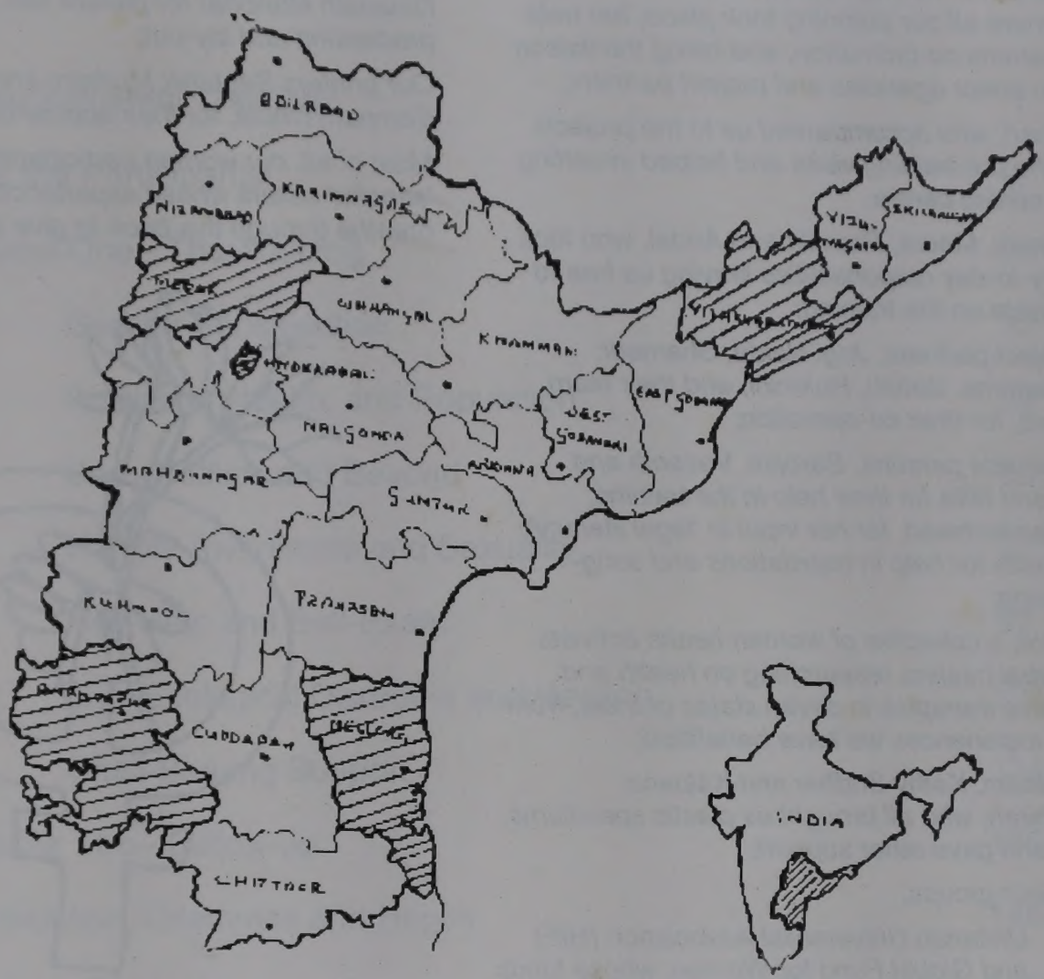
Mumbai 400064, India

to women health activists
for 'self-help' to enter their lives
and their work...



We thankfully acknowledge

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Those who wrote reviews for the first edition:

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Sharmila Joshi, for Women's Feature Service;

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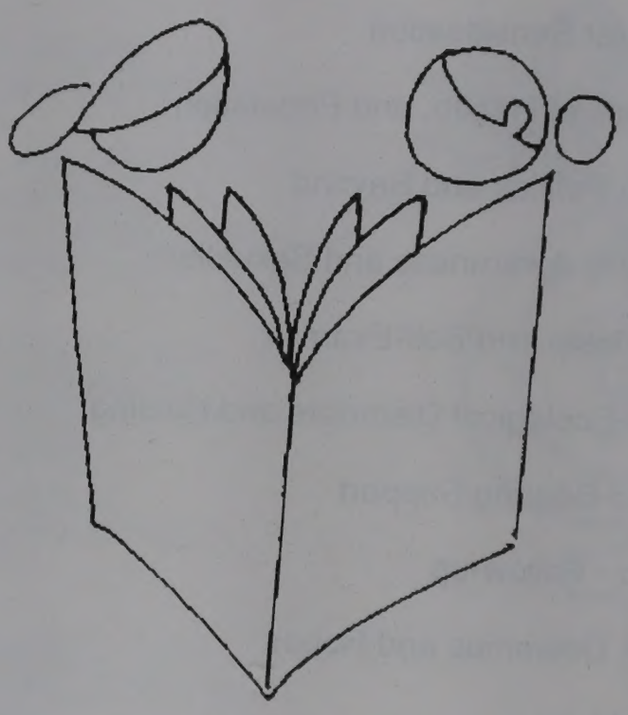


1

Why Self-Help Training?

Between February 1993 and November 1994, we facilitated a *Self-Help Training in Women's Health* based at Hyderabad. In writing this book we have taken on a challenging and daring task of conveying the experiences of all eighteen of us who have journeyed together. The process of recalling and interpreting this sharing has been delicate and sensitive... It has been so involving and intense, that we have heard and felt the voices, the warmth and the spirit of these women friends.

Earlier Experiences

Before this, we had gathered about fourteen years of experience in training of health workers at rural level in southern India. Each experience taught us a lot and made us take steps towards grappling with the realities of women's lives. This training is yet another mile-stone.

When we began our work in the seventies, we looked at health as a class-and-caste related issue. We worked in poor communities, and our training of health workers questioned the modern medical system that benefits the urban rich but neglects the rural and urban poor. We focused on over-all irrelevance and injustice in health care - curative, urbanised, specialised and increasingly privatised. But, as our experience grew, we found that, even among the poor, women are the most oppressed and their health suffers most.

For a time in the mid-eighties, we met regularly with a small group of friends in Bangalore. Together, we read OUR BODIES, OURSELVES by the Boston Women's Health Book Collective. In private, some of us explored our bodies, including the 'forbidden' sexual and reproductive parts, but we never did it in a group. We thought about starting a 'self-help clinic' in Bangalore. This idea had to be shelved due to pressure of other work, particularly coping with violence against women. Our regular self-help meetings stopped, too.

In 1990, we made a deliberate choice to work with women - especially *dalit*, tribal and otherwise marginalised. Here began our quest to look at 'health' through the eyes of women, to look into their status more deeply, and to identify their real health needs.

During the following two years, we did trainings in association with the Deccan Development Society (DDS) in Andhra Pradesh. It involved sixty *mahila sanghas* (local groups of village women) in comprehensive training for 'empowerment', and it had a definite impact on these women's lives. The women organised themselves around issues of livelihood linked to their health. Not only did they press for proper functioning of government primary health centres (PHCs), but they reflected on basic questions like

Why do we fall sick?

Why don't we have enough water even for drinking?

Where is the food? Why can't we get grain at the ration shops - where is that thing they call the 'PDS' (public distribution system) ?

How have all our fields been converted to cash crops?

Why are special health services centred in the cities?

They surveyed vacant lands and water resources, and got the district collector to sanction deepening of wells and ponds. They collectively grew food crops.

During our work within DDS, we became aware of SHODHINI which had opened a fresh path for women's health work. Twelve health workers of DDS had participated in their training-and-research process from 1988 to 1991. At the end,

the rest of the health workers asked us to conduct a similar kind of self-help based training. Besides skills in assisting at child-birth, they also wanted to handle common gyn-ecological problems and do abortions.

We re-contacted participants of our previous trainings. All responded that concerns of women are utterly neglected by both government as well as voluntary health sector. They added to our pile of requests for training inputs to deal with gyn-ecological disorders, assist at child-birth and even to do abortions.

Visits to primary health centres and encounters with private gynaecologists showed us how little the 'modern' system has done for women, especially poor and dalit women. Everywhere women were treated shabbily - called irresponsible, unhygienic, looked upon as passive, domesticated consumers with money to waste. Women had no right to ask for information or to question.

The Idea of This Training

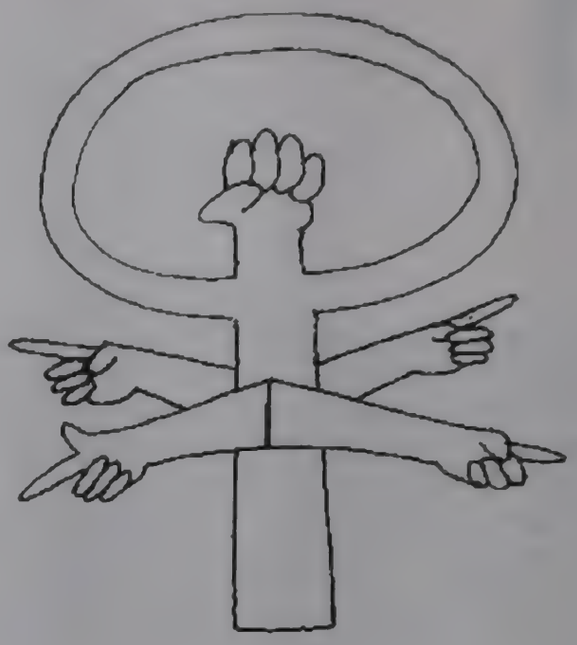
Towards the close of 1992, members of ASMITA - a women's resource centre - and other friends in Hyderabad urged us to do a training, not just with health workers of DDS but with women from other projects in Andhra Pradesh, too. They suggested that those trained should be enabled to train others in turn. ASMITA does gender-sensitisation training and legal-aid counselling, and prepares audio-visual materials and publications in regional languages. The group documents women's writings and conducts occasional research studies. They assured us of organisational and fund-raising support for our effort.

At the outset, we must admit, *we had doubts* about using self-help methodology. We ourselves had never been trained in self-help.

Would we be able to evoke an atmosphere in male-dominated NGOs for women to explore their bodies? Would we be ready to look at our own bodies and reveal them to other women? In a group with class and caste differences, would the self-help methodology be viable?

We were fearful about the outcome.

Would the projects accept such a radical programme? Would they accept the women as they grew assertive, and as they start to question in their organisations? Were we ready to take the risks as independent trainers? Would ASMITA support us if there was a backlash?



Our journey started with all these questions. It was like venturing into the dark unknown. We even looked around for someone else to conduct the training.... But, ASMITA firmly placed trust in us. They were keen that we do it ourselves.

Still, we needed some more assurance. We visited friends in Pune, Delhi, Nagpur, Bombay, Bangalore and Madras to share the idea and look out for resource persons. Also, we searched for self-help experiences in our country. SHODHINI activists described to us how self-help training had empowered rural women and had enhanced the skill of local women healers. Rina Nissim encouraged us and offered reflections and suggestions through letters. All this helped us venture forward.

Abortion was a difficult area. Women depend upon abortion as one method of birth control, and desperately need safe abortion services. However, since there are no facilities to deal with complications, friends advised that we should not take it up. While this view alone did not discourage us, we decided that sounder preparation would be needed before we could include it in the training.

We worked out the **aims** of the training -

- to assist women to re-cast their self-image and confidence, by validating their experience and knowledge, and improving their health through self-help skills,
- to uncover and probe into gender, class, and caste-based biases and trends in the medical system and in society,
- to see into and challenge beliefs, practices and institutions through which men control and exploit women's minds, emotions, labour, sexuality, fertility and property,
- to encourage individual and collective action and net-working for women's empowerment, and
- to look at health as a basic right and to press for government and social accountability to the concerns of women.

Pre-Training Efforts

Once the needs were identified and the aims were decided, we set about ***selecting projects*** which would send their team members for the training. It was bound to be a radical kind of training from the projects' point of view. Not only would we focus upon women's health, but we would also look at the politics of it and zero in on women's subordination. While questioning the dominant health care system, we were not going to play a mere game of seeking new ways. We needed to locate projects that could trust and give scope to a feminist approach and encourage local women's collectives in the form of *mahila sanghas*.

In the project selection, we were helped by Indira Jena, a member of ASMITA, and an active member of SPANDANA, women's network in Andhra Pradesh. We sent invitations to eight projects. Four responded saying they were interested in becoming partners to the training -

- Adarsh Rural Integrated Development Society (ARIDS), Bukkapatnam, Anantapur District
- Deccan Development Society (DDS), Pastapur, Medak District
- Speak India in Rapur, Nellore District, and
- Sharada Valley Development Society (SVDS) in Anakapalle, Vishakapatnam District.

The locations of these four projects are shown on the map near the front of this book.

Pre-Training Workshop

The concept of self-help was new for them all. To seek the confidence and full co-operation of the project partners, we had a ***workshop*** for two days. The four project directors, women members of their staff and ASMITA attended. We explained the *perspective* and the *content* of the training. There was opportunity to go into details and some intense discussions resulted. We tried to give a reasonably clear picture of what the projects would be getting into, including the aspect of *replication* of the training in their areas. On their part, the project partners tried to understand the responsibilities all of it would entail.

It was decided to hold the first training phase at Hyderabad for *six days every month*. For the participants, this would mean being away from home and work-place for a whole week. To help the participants remember, we kept to the same dates every month.

In the second phase, there would be a shift of focus to field situations, involving the projects directly. It would include 'women-and-health programmes' with the communities and the setting up of 'women's resource centres'.

During and after the training, follow-up in the project areas would be essential. The training would only start the process. Follow-up would let us see the *impact* on women's health concerns and the gaps that still needed work. The project partners were happy that a 'follow-up component' was included.

We decided on ***distribution of responsibilities*** between ourselves and the project partners with regard to selection of areas and participants, stipend and travel allowance, help in conducting surveys, visiting facilities, conducting the follow-up programmes, net-working of self-help efforts between projects and others, and setting up of women's resource centres. We sought assurance from the project partners that participants would complete the training, and that attention would be given to building support systems within the project.

After giving a brief presentation on the 'politics of health', we helped the women staff to set up criteria for ***selection of areas*** within their projects. This was aided by drawing a map of their total work area and marking the facilities available to women, the poor, dalits and other minority

groups. From these maps it became clear where to reach out

⇒ *to villages that are remote, neglected, with scarce transport facilities and no health services.*

Being 'women organisers', the staff had other responsibilities besides 'health'. So, to be practical, we limited ourselves to taking up self-help work in *five villages each* in the first year. After that, more women would be trained by the projects to extend the work to other villages.

In the ***selection of participants***, we sought to build a foundation for programme sustainability and autonomy. We kept in mind the requirements and potentials of the self-help approach, as well as the need for collective action and decentralised net-working.. We needed to train *women in each project* who could take over programme responsibilities. But, from experience we knew that there is a high turnover among project staff women, and hence the programme should not depend too heavily on them. On the other hand, *women from the local mahila sanghas* live permanently in the project area.

It was decided to select participants from both project staff and sangha members. We hoped that, thus, they would take up responsibility together for further training, organising women to put demands on the local government health system, and setting up women's resource centres. For some time, at least, the project staff participants would give support to the sangha member participants.

The issue of ***stipend*** came up for the sangha women, who would lose a whole week's wages every month while attending the training. It posed a problem because of the difference in wages between the four project areas. The stipend was fixed by taking the average, at Rs.25/- per day.

Selection of Participants

Selection of ***project staff participants*** by DDS, SVDS and Speak India was done prior to the workshop, based on their interest and experience. ARIDS was able to select their participants only after attending this workshop, as they had to recruit new women staff members.

Keeping in mind the training objectives and our previous experience, the following set of criteria was worked out for selection of ***sangha member participants***:

Age:	25 to 50 years
Education:	semi- or neo-literate
Experience:	traditional healing knowledge, practice as dai
Life Situation:	relatively free from family responsibilities, available to all women, especially poor, dalit, and tribal; preferably single

We thought that once we set up criteria for selection, it would be easy to find women, but it was difficult. We had presumed that single women are 'free'. Actually, they are loaded with burdens caring for their families and others! Inspite of all the unforeseen problems, we got at least two sangha women from each project.

After the pre-training workshop, we made ***visits to the projects*** to get acquainted with their structures and activities and to take a look at the areas they served. We kept some questions in mind.

How stratified is the community? What are the economic and political factors that will affect the work of the participants? What is the status of women? What health facilities and social supports are available?

Working with each project during participant selection, we visited the local sanghas, too. We met all the participants.

What are their roles in the organisations? To what extent are they involved in making policy decisions, in planning and in implementing programmes at field level? What is it like in their families?

Vision of Women's Resource Centres

During the pre-training workshop, we introduced an idea of 'women's resource centres' to be set up in each project area after the training.

These centres would seek to evolve and provide a different kind of health *care*. While promoting each woman's right to health, they would give space for women to speak and learn about the silent areas of sexuality and fertility, enable women to do self-exam, understand their problems and find remedies. The centres would also encourage women to share all kinds of problems and struggles. Through personal and collective counselling they could seek and find solutions.

We visualised them to be true *women's spaces*, planned by them, expressing their creativity and culture.

A Space for the Training

We had selected participants, planned the content, and we had contacted resource persons.

Now, to let the training unfold with feminist perspective and methodology, we needed *to prepare a space*. None of the training institutions could give us privacy, so we rented a flat, organised cleaning and cooking and fixed our timings to suit the needs of the women. As the day of arrival drew near, we were flooded with apprehension.

Will it be possible for such a large group to be accommodated in a four room flat?

Beginning in the month of May has its own problems. But the women came and dispelled our fears. This was their off-and-on home for so many months. They were not disturbed at all by the limited space and scarcity of water. As rural women, they were used to the freedom of the countryside to answer nature's call. Faced suddenly with restrictions, they happily rose to the situation, finding open spaces within the surroundings. Our curious neighbours frowned, watching them trot off together in the early morning each with a *chembu* (small vessel of water) in hand. Bathing in groups, they adjusted to water and space shortage.

Our ***morning body exercises*** helped us to unwind and relax our tensions, and it gave us a lot of energy. We had aerobic and pelvic exercises, and some yogic *asanas*. Some movements were similar to motions of work back home - they loosened our limbs and spines stiffened from sitting long hours. They helped us to be in closer touch with our bodies and it eased and assisted us in healing work. We had much fun laughing, singing and dancing.

We experienced a deep feeling of well-being and freedom in this new space.

Aside from having briefly met during our pre-training project visits, we did not know each-other before the training. Yet, the barriers between us soon fell away

2 We, the Participants

We are different persons.
Listen to what I'm trying to say!
Tears are my strength.
Let me live.....be respected...
I 'm still young.....
I won't take this beating anymore - I won't!
Don't clip my wings - I'm like a bird that wants to fly!
Finding my 'sexuality' was beautiful!
If only I have the courage.....

Sathyavati
Navneetha
Pushpa
Lakshmi Narsamma
Subbamma
Suvarna
Nageshwari
Sathyamma
Vasantha
Sivalakshmi
Ravalamma
Saroja
Parvathamma
Lakshmi
Ramalamma
Nagamma
Sabala
Kranti

Our Self-Help Group

Before each of the participants begin to speak, we would like you to know more about our group as a whole. We were eighteen -

6 from project staff teams

9 from *mahila sanghas* in project areas

1 independent activist from Hyderabad and 2 of us.

Out of the eighteen of us, all nine sangha women were wage-labourers, the six project staff women plus Vasantha were of lower-middle class, and us two middle class. The project staff women were all literate, while the sangha women were all non-literate. Among us, four belonged to *dalit* castes, four to the *enadi* and *lambadi* tribes, three to *'other backward castes' (OBC)* and five to *'forward'* castes. Fifteen were of rural background, and three of us were from large cities. Eight among us were married and living with husbands. Of the *ten single women*, three of us were unmarried, three deserted and four widowed. The youngest among us was just eighteen, and the eldest was forty-seven.

Each needed time for expression and integration within the larger group. All of us had our own cultural and personal identities - the experiences, perceptions and needs of each of us differed. We tried to be sensitive to this diversity, always. To create an environment free of fear, to evoke respect for each one's differences, to evolve a spirit of mutual trust, we built upon the common aspects of our struggles and of our identity as women.

Breaking the Ice

On the first day we spent time to get to know each other. In our first session together, we started with some lively *introduction games.* Then, we played two *trust games* to help build confidence in each-other.

⇒ *Balancing:* Three groups formed circles of five. One volunteered to stand in the middle and let herself sway backward, forward and side-ways. The other four had to be alert to support her from falling. Each took turns in the centre. The groups urged each member to do it again until she felt free and relaxed to trust the outer circle.

⇒ *Throwing Up and Catching:* Next, two groups stood in two parallel lines while one lay down in the middle. They lifted her and tossed her up, together catching her as she came down, being careful to support her neck and lower back. They had to move together in co-ordination as she landed in their arms. It surprised us all that the height and weight of the one in the middle was no big problem. All wanted to try it out.

After each exercise, there was time for the one in the middle and those on the sides to share with each-other what it felt like.

In the beginning, it wasn't easy to trust the others.

It's easier to fall towards those from my own place, my project - I'm sure of their support.

I was afraid the ones in the circle wouldn't be alert, they might have let me fall!

I looked out to find the bigger and stronger one.

To gain someone's trust, you need to work hard.

It doesn't matter if you're big or small - it is the knack of supporting.

When I wasn't sure, my body felt so stiff and heavy!

We had to work as a team. She might have fallen and got hurt...

Trips Through Memory Lanes

With this basic experience of trusting, we were ready to take a 'journey through memory lanes'. To coax our-selves to imagine wandering back into childhood, we lay down on the floor, relaxing every muscle. We used soft music to lull ourselves into a sleep-like state, and we sank back.... as far as we could... into our pasts....

For most of us, it was the first time such an inviting space had been created to reach into our innermost world. After about forty-five minutes, all of us seemed to be ready to come back. We got up and came together in a circle. Still, there were long moments of silence. Then, story after story unfolded -

about childhood
growing up
..... being a woman
obeying and compromising
struggling and suffering
and sometimes rebelling.

Sathyavati

Sathyavati is plump and loving - the participants called her 'Mummy'. She lived up to her nickname, always mothering, making everyone happy, cracking joke after joke.

But, after we had journeyed through memories of childhood, youth, and marriage, Sathyavati waited, not speaking out like other women. We thought she didn't have much to say. At last, she unbottled herself.

We are two sisters. My father had lot of land, but today we are landless. Of course, he lost it all because of drinking. My father died when we were very young. My mother worked hard to educate us. My elder sister was able to complete school. But I studied only up to eighth standard. I was made to sit and look after our vegetable shop. All those years my mother had never gone out to work because she was ashamed. But when my father died, she had to work to support us all. The vegetable shop was just outside our veranda.

Sathyavati started crying. We let her cry. Then, through tears she said,

I never forgave my mother for keeping me back from school. Last week she died while crossing the railway track.

After a while she continued,

My mother's family is well off. She had a younger brother, and she wanted one of us girls to marry him. My elder sister went to college and fell in love with another boy. She wouldn't listen to my mother. I was the one left. My mother forced me to marry her brother, my mama. He use to drink a lot. He was in the military. I cried and pleaded with my mother, but she explained that every woman must have a home to live in. I must marry her brother. Otherwise, she, too, would be forced to move out of her parental home and live on the roads.

I felt sorry for my mother, and so I agreed to marry my mama. I was only thirteen years old. He took me off to Pune. We lived in the military cantonment area. All day, I used to be left alone in the room. Every one spoke Hindi or Marathi, and I knew only Telugu. So I couldn't talk to any of the neighbours. Often my husband use to lock me in the room till night. Then, he would come home drunk at odd hours. He used to insist on me cooking according to his taste. He wanted chappaties, but I couldn't roll them round enough, so he would beat me. I use to feel so sleepy when I had to cook at eleven or twelve at night. All day I used to cry. Crying was the best way to relieve myself, I discovered. After crying, I used to feel relaxed for some time. When I got pregnant I came to my mother's house. I told her everything, but she made me return to him.

I have two sons and a daughter. After my third child, my womb had to be taken out because of sudden bleeding. They never told me what was wrong. The doctor advised me not to relate for some time. My husband forced me to have sex with him, even though I refused. He's lost patience with me now, and has another woman. Everyday he goes to her. It's five years since I've related with my husband. My children are grown up, but I'm only thirty-five. My husband doesn't care about me. So I have to work to earn my living. My sister is doing well, and she regularly gives me money.

After taking retirement from the army, Sathyavati's husband joined a factory. During the self-help training, he got into a financial fix. Without her knowledge, he had taken a huge loan and had not repaid it. The brokers came to mortgage her house. We tried to support her. We suggested that she go and speak to the union people at her husband's factory, tell them that he didn't bring his salary home. She did it. Her husband got to know and he beat her. Ultimately, she sold all her jewellery to pay back the loan. Recently he had an accident and his fingers were cut off.

He's back home now and expects me to look after him. I've no choice. The other woman doesn't want him now - he's without a job. I feel it's my duty to look after him...

We felt her frustration and shared her distress and anger. A strong woman like Sathyavati saying this! But she continued,

I have a grown up daughter. She is of the age for marriage. If I send my husband away, I wouldn't be able to get my daughter married. Yes, he is a burden to me. What can I do? At least, since he is at home, the neighbours feel my husband is back. It makes no difference to me. He doesn't talk to me. I cook. My daughter serves him.

For Sathyavati coming to Hyderabad each month for training was an escape from that house. She would make all of us feel more alive, as being with the group was her release. But always on the day to depart, Sathyavati would lapse into silence. Her blood pressure would go up, and she would get all kinds of aches and pains. She dreaded going back.

Once while I was travelling from Vishakapatnam to Hyderabad in the second class general compartment, there were some men in the same coupe. In the morning I went to wash my face. When returned to my seat, one of the men asked me why I had not applied a bindi on my forehead, saying, 'Your husband is alive. He's your God. You are dependent on him - you are bonded to him.....

I said to them,

He's not my god - he is my enemy! How can you men call yourselves gods? My husband causes me so much suffering. I can not respect him!

When others in our group talked about their relationships with partners, Sathyavati would go into her moods. One of the younger women said to her,

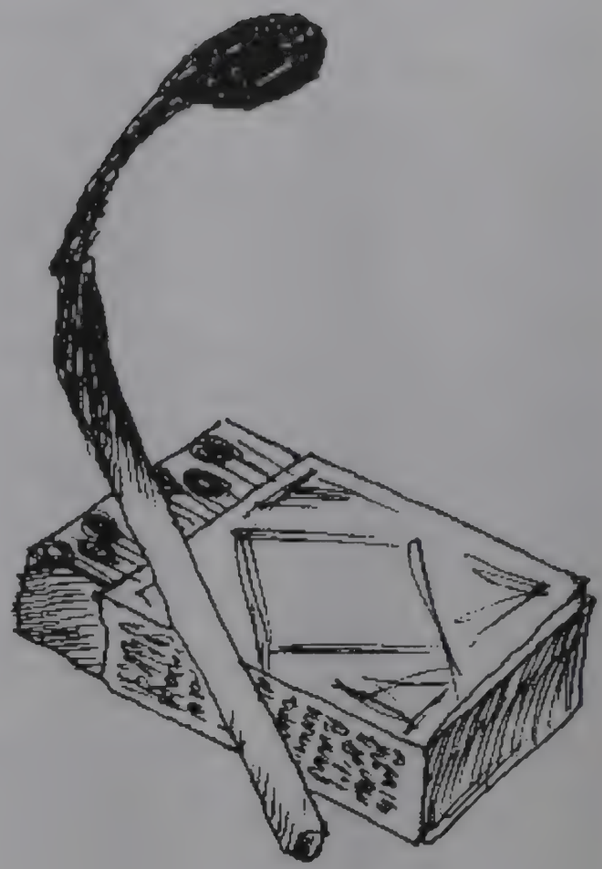
Akka, you've suffered so much - do you still feel something for your husband?

There and then, the tears flowed... they spoke to everyone, and no one touched the topic again.

Inspite of family problems and ill-health, Sathyavati did not let it deter her from attending the training and follow-up programmes. She became stronger and confident in the group. In her village she is looked up to as a leader. Women come to her with problems. She uses her knowledge and skills and has built up a lot of experience. She is not afraid to speak out whenever she gets an opportunity, whether it be with the ANM or the doctor at the PHC or when moving around.

She has now been elected a member of the Mandal Committee.

Navneetha



Navneetha is my name. I'm the youngest of four children. I spent most of my girl-hood in a hostel - don't remember anything about my first period. In the hostel nobody paid attention, so there was no celebration. It was just like any other day. I studied upto tenth. I had lots of ambitions, but as soon as my schooling finished, without asking me my parents got me married.

My husband was much older than me. He had a sweets store. Within a year of my marriage I conceived, and gave birth to a baby girl. My husband was always suspicious of me. My daughter died of simple diarrhoea when she was a year old. This was a terrible shock. On top of it, my husband mentally tortured me and beat me. I got sick, and often I thought of killing myself. But, with my neighbours' help, I stood it all.

My mother took me home. To distract myself, I re-started my education and finished my B.A. Then, my husband negotiated with my family and took me back to his home. This time, the torture was even worse. Every day I was beaten. My in-laws had taken over the sweets store and they snatched even my husband's small earnings. He

became very violent, and he imagined things. He doubted my every movement.

One night he came home very late. I had waited and hadn't eaten, but still he beat me up. It was too much - I ran out of the house and lodged a complaint with the police. After this incident, he wanted to kill me. Every night I felt terror - I feared I wouldn't see the next morning. I couldn't go to anyone. The neighbours saw me getting hurt everyday, but they seemed helpless to do anything.

One day, when I was about to bathe, my husband came and snatched my clothes from the door. I managed to get the clothes back from him. Just as I took up the mug and poured water on myself, I realised he was throwing kerosene over my body! He lit the match-stick and threw it, but I was wet and I didn't get burnt. I covered myself with the sari, grabbed the match box from his hand, and ran out to the police station. I told them that my husband had tried to burn me and threw the match box before them!

As the police took down my complaint, our neighbours burst in shouting that my husband had burnt himself. The police rushed to our house. My in-laws all accused me of burning him. He lay in the hospital for five days before he died, and it added to my torture. I refused to go and see him. I pleaded with the police that he was trying to kill me and he committed suicide. My neighbours had seen my torture and gave testimony, so I was released from the hands of the police.

My house was burnt. I had no place to stay, and no land to live on. I moved in with my aged father. I started working, and thanks to the sanstha (an N.G.O)where I work, I am able to stand on my feet.

It is eight months since I started experiencing the trauma of being a widow. I am twenty-six years old. Young and good-looking, they say. I have lots of desires, but no one understands! I miss my little daughter terribly. It is difficult as a single woman to face life and to live.

Navneetha is a 'women organiser' in the project where she works. We had met her at the pre-training workshop and on our visit to her project, and she was keen about the training. During that visit itself, we saw that Navneetha was close to one of her male co-workers - a married man. As a single woman, she could be easily exploited in this relationships. So this was another reason for selecting her - we wanted to see her strengthened and independent.

During the training session on Fertility Awareness, Navneetha was impressed by the group's discussion about normal and abnormal vaginal secretions. After that, a sangha woman came to her with a 'white discharge' problem. She took the woman to a doctor, who just wrote down a prescription. She asked him,

What kind of white discharge is it? Is it infected? What is it called? For what is this medicine?

He looked up at her, answering,

You aren't trained. You can't understand. You must study many years. Only a doctor can say anything about white discharge. Take these tablets and everything will be alright.

She replied

Give me three months. I'll come back and tell you...

Ambitious and hard-working, every month she returned to her project feeling stronger. Knowledge and information were strengths for her!

Unfortunately, back at the project the other team members couldn't appreciate it. They envied her for being in the training. She couldn't get their approval or support. This may have been one reason why she moved closer to her male colleague. She shared things about the sessions with him. In turn, he reported it to the male project leader who became very upset. This incident ballooned into a crisis in the project, and the training came under fire. While the participants were saved from discontinuing, and Navneetha didn't lose her job, her male co-worker was asked to leave and she had to agree to stop seeing him.

For the rest of the training Navneetha was not the same. She was nervous and lacked confidence. She went into a shell and wouldn't come out. We worried about her. Would she get enough appreciation and encouragement from her organisation, or from her team of women?

We keep exchanging letters with Navneetha. We hope to see her breaking the bonds of silence again, starting work among the poor and tribal women of her area, and taking up new risks. Recently, she has joined the SPANDANA network. In this wider space she may find women like herself. In collective struggles, she may come to life again.

Pushpa

Pushpa works as a 'health organiser'. She has much experience using herbal medicines for women's health disorders. She also trains health workers. We selected her so that she could in turn train women health workers in self-help.

I come from a poor Reddi family. I've lived through a lot of discrimination and neglect. I studied upto the third standard, but my parents just refused to hear of me going on. Everyone else in the family is educated. I had to do the housework, take care of the younger ones, prepare food and so on. I was never properly clothed or fed. They got me married before I could even drape my own sari.

When I went to my husband's house, I felt like playing with the other children. No one understood me. My mother-in-law didn't like me. When I was two months pregnant, I miscarried. I was left alone, and I thought I would die. When my mother heard of it, she took me away from them. I stayed with her for two years. But you can't go on staying at your mother's place. So, I was sent back. I gave birth to three sons. We have a little land which my husband used to cultivate.

Next to my house there is a sanstha. I was asked to work as a balwadi teacher. My husband said it was OK, but my other relatives were angry.

'You are a Reddi! How can you mix with harijans?'

I didn't care. The happiness didn't last. All of a sudden, my husband got an attack of diarrhoea. Before I knew it, he died. I was shocked. The children were so young. How would I bring them up? To lose a nice man on whom I depended so much...I got a lot of emotional support from the women in the sanstha. Their courage in their own lives helped me to look at mine and start living again.

My in-laws set about grabbing the little piece of land. As my sons were too small to fight, I had to resist alone. I was upset and couldn't think straight. To add to it, I had a problem with my periods, and there was not enough food at home. I got support only from women of the sanstha. Because of this, I was able to fight, and I kept the land. Even though I am a woman, I ploughed the land myself.

Today my sons have grown big, and they help me. I am only thirty years old, but all my hair has turned grey, and I look like an aged woman.

As a widow, everyone expects her to be sexless. But the young woman within Pushpa loves to dance and sing. The morning exercises were a great pleasure for her. She was the first to change into *salvar-kameez* to do them. At first, she had lot of worries about being away from home.

Who will cook for the boys? Who will milk the cows. Who will manage the house?

Slowly she realised that life goes on, and her boys were forced to take up more work at home.

Coming to Hyderabad gave Pushpa new status in her project and her community. She became confident and assertive. It changed her relationships with the other health workers. She gained more training skills. The project gave her the opportunity to replicate the training. She improved her writing skills by helping us prepare our programme reports. Knowledge of herbal medicine instantly gave her value in the group, and she never hesitated to share it.

Lakshmi Narsamma

Lakshmi Narsamma is around thirty-five. She works for her project as a 'women's organiser'. She is talented and sings well. She has leadership qualities. She enabled the group to take over much of the decision-making and daily routine, leaving us free to meet other demands of the training.

I belong to the Enadi tribe. Since the British times, the Enadis have been labelled as a 'criminal tribe'. When I was small, we used to move from place to place in search of work and shelter. In each place we got ourselves attached to some landlord. I came in the middle of five children. My father hunted, while my mother usually took care of a guava orchard. We lived in the forest close to Tirupati.

I did go to school and studied a little. There was a temple close to our thatched hut. A brahmin poojari got interested in me. He approached my parents and proposed to marry me. Of course, there was lot of discussion. He was very old compared to me. But when it comes to high caste and a tribal community, I suppose age doesn't matter. After much hesitation, I did get into some kind of marriage with him, and I had a son with him. But when my son was still young, my husband died of a heart problem. He left a good sum of money behind to take care of myself and my son was only 18 years old. I came back to my mother's house.

A man use to visit my family regularly. He worked in the police. He was of my tribe. We got interested in each other and went in for a registered marriage. Actually, he was already married. Through him I had a daughter. He is violent, and later he began torturing me. Violence is normal for him. I didn't confide with anyone. He would leave me now and then to visit his first wife. When he came to me, I use to have a fine time. I had a strong urge for sex. But I could not bear his beating anymore. I left him and returned to my mother's house with my son and daughter.

Now there is an arrangement that he visits me a few days every month. He knows my timings. As soon as I return from the training, he visits me. Now that I have a job, and the children are being educated, I have my way. I can get him to do things the way I want. I have invested the money left to me by my poojari husband in fixed deposits in my son's and daughter's names. This husband will not get a paisa of it.

Lakshmi Narsamma shared her life experience easily. She often used to volunteer for any challenging task. Navneetha and Lakshmi Narsamma came from the same organisation. Tensions at the project surrounding Navneetha affected Lakshmi Narsamma. She got confused about how much should she share, in both directions. We tried to be sensitive to the fix that she was placed in, but we had no control on what happened at the project level. She complained of severe pain at the back of her head and called it 'mental illness'.

She picked up herbal medicine, and it got to be one of her strengths. She organised women in her village to go trekking into the forest, to collect different plants and then to process them for use in the health work. Also, she introduced a kitchen garden in the back-yard of every home in two villages. That resulted in a notable improvement in the women's health. Lakshmi Narsamma would often turn up with small innovative plans to share with us.

Subbamma

Subbamma comes from a tribal hamlet cradled in the foot-hills of the Eastern Ghats. It is about fifty kilometres from the mandal headquarters. She is about thirty, and she lives with her husband and four children. She belongs to the *enadi* tribe. The thirty families live in a small hamlet some distance away from the caste village of *reddis*. Sixteen years ago, government plots of land were distributed among these tribals. Each family received a quarter hectare of irrigated land. The land lies fallow, however, because they couldn't manage to gather the means to cultivate it. The health of all the men, women and children is poor. During our visit to Subbamma's village, stark malnutrition and severe anaemia stared back at us. Many families were emaciated. It was the height of summer, and they were living on fruits, roots, honey and small animals from the depleted forest.

The families were interested in the idea of a health programme.

Government people only visit the caste village. They ignore us when we go to the PHC. Are we not human beings?

Another said,

The ANM visits the caste village once a month, but she never comes here. Yes, she does visit us once a year to achieve her target for operations. Nearly all our women have had tubectomy done.

It was not difficult to select Subbamma. She was an active member and was respected by all. They wanted her to be trained and to help them.

Until now, I have never been out of my village. The farthest I have travelled is to the mandal headquarters to visit the PHC. I never sat in a train before coming to Hyderabad. It is like travelling far away. All in my village wait for me to return and give them news of the city. They ask so many questions. I have never been to school. But here I sit with some of you who are educated, and we learn together. In the village they can not understand this, because these caste people treat us as if we are dumb creatures.

I was married when I was twelve, and I have two sons and two daughters. My husband is good, but he takes life easy. He loves to roam in the forest. We have little land. I was keen that we all work on it. But my husband prefers going for coolie work. When I go back every month I try to do some work on the land. My husband drinks daily, but he doesn't beat me. In our place, both men and women drink. My biggest problem is survival.

My son is the only boy in our hamlet who has got a chance to go to school. I put him in the government ashram-school. He studied through the tenth standard but failed. Now he sits at home. All my dreams are broken. Why does he behave like the rich? Why can he not work on the land? I asked him to teach night-time literacy classes, for all of us in our hamlet, but he refused. He wants to go to the city.

Subbamma spoke in her *enadi* dialect, which the women from other places in Andhra could not always understand. Even so, whenever she spoke, she commanded their attention. When the group members made their drawings showing their body perceptions, Subbamma had the courage to differ from the 'educated' participants.

Why have you broken up the body?

Once she had broken the silence that day, none of us could ask her to stay quiet. After the session on Politics of Health, she said,

One thing I can tell you for certain. Now, I have got confidence to talk! First, to talk to my husband and other sangha members. I asked the ANM why she never visits our hamlet and why she only visits the rich in the caste village. At the sangha meeting, I told Rakku's story to all the other women. They said they would help me to ques-

tion and get health facilities from the government PHC into our village.

Men drink and women also drink sometimes. I told them to improve our situation, to improve ourselves, we have to stop drinking. This is because alcohol keeps us poor. It does not help us. Instead we fall sick. They said they will think about it.

Subbamma was happy for the opportunity to learn reading and writing. She kept up with it until the end of the training. She was the only one who used to carry the literacy primer home.

She shares openly about her body. Because of Subbamma, we never lacked good 'live visuals'. This helped especially when the charts were not clear. Her mother-in-law attends to women in childbirth, and Subbamma now assists her. The childbirth training has let her natural confidence grow. She is calm and sensible even if complications or difficulties arise. She has safely managed a 'breech' childbirth, and now word of her skill is spreading to other villages.

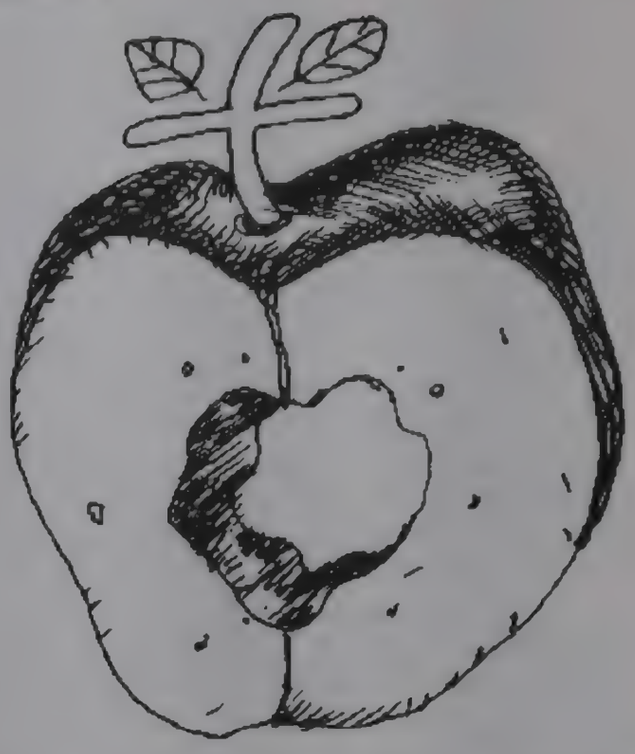
During the women-and-health programme at SVDS Anakapalle, it struck Subbamma that the women who came treated her no different from the rest of us, educated or not. At her project, she was used to the odd jobs like filling water and cleaning up, while here she was sitting with all sharing the same work . She helped taking life-stories of local women and guiding them in self-exam, they didn't seem to care whether she was a tribal who could barely read and write. She said glowingly,

Women can see our heart, our face, and they know who is for them. I feel very proud today!

Subbamma is keenly observant. So far from a town, still she has quickly picked up new skills and techniques. We were taken aback seeing how she pulls a rubber glove onto her hand. Sometimes, we are troubled by a thought - might she turn into a petty 'doctor' like those that roam the desperate countryside?

Although Subbamma reads and writes only very slowly now, she equals the school-educated participants in other ways. She holds more responsibility in her organisation. Promoted as 'health organiser', she has been given three villages to work in. We hope the project will continue to give scope for her originality.

Suvarna



We got to know Suvarna briefly in 1991 when we did an awareness training programme in Medak District. Having lived through desertion herself, she wanted to do something for the other deserted women in her village. But, she had to take care of her aged mother and disabled sister, surviving by doing coolie work which brought her only five rupees a day. Her constant struggle for livelihood kept her from reaching out. At selection time, we thought of Suvarna. If she got training, she might gain a reasonable livelihood and be able to help others, too. The women in her sangha were happy to send her.

I have four sisters and one brother. We were all very small when my father died. My mother brought us up on the little land we had, She got me married when I was just eight years old. After five years, I got my periods and I was sent to my husband's house.

I didn't get on well with my mother-in-law . She didn't understand me and scolded me for little things. After five months, my periods stopped. Everyone felt I was pregnant. In our custom, we are sent to our mother's house for the first birth. But they said they wouldn't send me. I was awfully upset. I desperately wanted to be with my mother.

One night my husband returned from a marriage party and insisted on having sex. He forced me. Right after that, I began to bleed a lot. I bled and had some pain, and then I passed a wet flesh-like

lump. Since it was dark, I couldn't see. There was so much bleeding they took me to the PHC twelve kilometres away. The doctor gave injections and pills for three days. The bleeding stopped, but ever since then I never got my periods again. When my husband and mother-in-law got to know this, they didn't show me to a doctor. Instead, they sent me back to my mother's house. They said I'm useless because I can't bear children. My husband hasn't come to see me since then. It's six years. I heard he married again.

When I came to my mother's place, an aunt of mine took me to an experienced dai in Karnataka. This dai had helped many childless women. She examined me by feeling inside with her hand. She didn't explain why, but she said I will never get children. It upset me, but still I haven't given up hope.

I always looked up to my only brother for help. But, ever since I have come back to my mothers' house he never talks to me, and all the time he seems to be picking a fight. It makes me feel bitter. He pushes all the burdens on me. I alone have to care for my mother and disabled sister. My brother fears that I will claim my share to the little land and the house. That's why he hates me. To add to it, people gossip and imagine things about me. I can't talk to any man. If I dress well, they pass comments! I'm just fed up with life. Why do I have to go on struggling like this?

Coolie work is back-breaking. My health is not good. I'm just twenty-two and I feel so aged. I only hope life gets easier after finishing this training, and I can earn a little more to stand on my own feet.

This is Suvarna, who came all knotted up and feeling hopeless. It didn't take her long in the group to realise that she has a whole life-time ahead, and her spirit need not be defeated. She was keen and open.

She grasped the fertility awareness information and for six months she charted her mucus patterns and other fertility signs carefully, despite not having periods. She felt she could detect that she was ovulating. Her hopes were raised again. She wanted to check-up again and know what was wrong.

We took Suvarna to a gynaecologist friend who examined her. She said that Suvarna's womb was very small, apparently undeveloped. She should give up hope of conceiving. Suvarna was depressed again. It took her some time to resolve this. The group interaction has shown her there is more to life than bearing children.

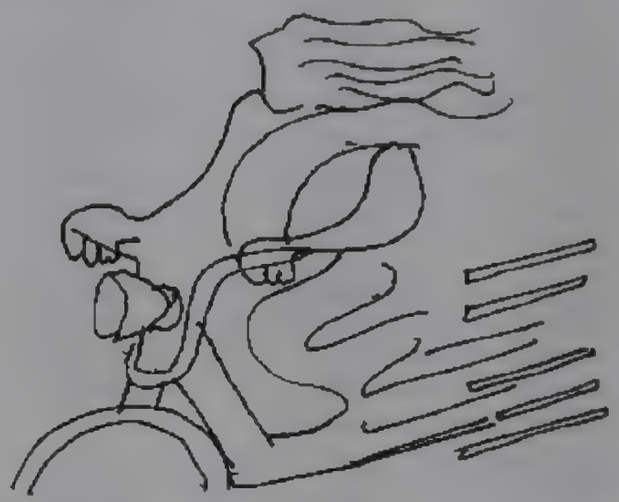
Although Suvarna was a sangha participant who had never been to school, she had a gift for grasping information, like the menstrual cycle. She could communicate it to others in a simple and clear way. She persevered with literacy and now can read and write in basic Telugu. She maintained her herbarium collection all by herself.

Suvarna did not tie the *rakhi* thread on her brother's wrist at *raksha bandhan*.

What protection has he ever given me?

Instead, she tied *rakhis* onto her mother, sister and other village women. Today, Suvarna is a health worker in her village.

Nageshwari



Nageshwari had been at the pre-training workshop. Actually, when we visited her project after that, we had another woman in mind for selection. We tried to dissuade her. Being responsible for health work in her project, and having understood the self-help principles she insisted on attending the training, and we felt we had no choice. Our doubts proved wrong.

Mine is a poor brahmin family. I was my parents' only child. My father died long ago, and my mother brought me up. I studied up to high school, and I was keen to keep on. My mother ended this by getting me married to her brother's son. Most of my friends went into some training or other.

My husband takes life easy. He tries his hand at business and sometimes ends up losing. How could I depend on my mother? I felt I must get some training and find a career. So, after the birth of my second child, I joined a private ANM

training course. Now I work in a project, and my mother takes care of my two children.

I had lots of problems with my pregnancies. In fact, I had four miscarriages, before I could give birth to my son and daughter. I've had very bad experiences with doctors.

Nageshwari is quick and ambitious and tries to accumulate knowledge. Her formal education was a block to her. With us, she had a tough time de-schooling herself. She had lot of plans and wanted to prove herself in her project. Fortunately, she found the space there. Small and slim, she puts herself forward, readily taking decisions. She could be bossy, too, and sometimes she used to speak rudely. She would get irritated when others were slow to understand or didn't know enough.

Somehow, a turning point in Nageshwari's whole attitude came when she did her own speculum exam. After that, she became out-going and co-operative. She made efforts to explain to others, and to help them learn.

It was really liberating for me. Doctors always put fear into me. I thought there was something very wrong...

She had a mildly descended womb and inflamed cervix. She took regular treatment, began exercises and started to be more careful about her health. Despite her orthodox brahmin background, she started eating eggs daily.

Nageshwari moves from village to village on her *luna* and can't afford much rest. She needed her husband's co-operation at home, and the session on Gender helped her get it! With insight into the subtle violence that women bear from the 'double burden of labour', she worked on her carefree and up-to-then irresponsible husband. Every month when she left home to come to Hyderabad, he was pushed to do more at home. Fortunately, when he saw his wife growing confident, he chalked it up as prestige for himself and he bragged about it to others. Nageshwari was lucky that he wasn't threatened by her assertiveness. For a time her health was poor, and he gave her a lift to her office on the luna. People teased him, but he took it well.

Nageshwari took keen interest in fertility awareness. During the training she worked intensely with a childless couple, Kusuma and Shankar. She taught them fertility awareness skills and gave him *ashwagandha* root powder for six months. When we visited after the training, Shankar came to tell us that they are going to have a baby! She has keen interest in using herbal medicines as an alternative to allopathic treatments.

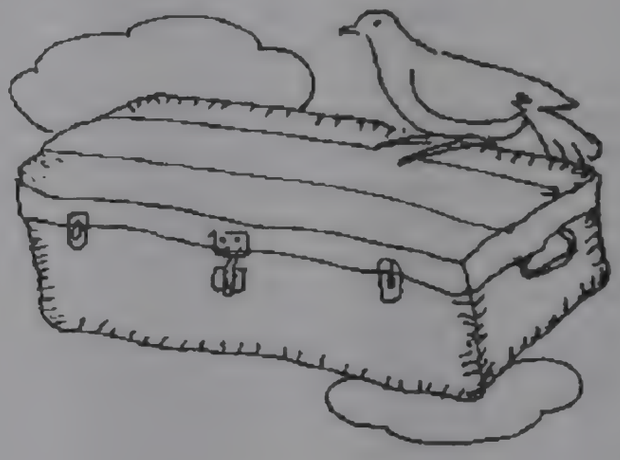
Nageshwari shared the training experience in her project without much difficulty. Her project leader gave her solid support and freedom to work as she pleases. The chance to conduct training always gives Nageshwari a thrill, and she has been invited by one of the other projects to help train their team. She has become active in the SPANDANA network.

Indira Jena writes:

She absorbs the most difficult concepts, linking them with her practical situation. The change in her is so amazing.

Despite back-pain, Nageshwari keeps on. She still needs to learn that relaxing and taking care of her health is *just* as important!

Sathyamma



I am Sathyamma, and I belong to a women's sangha. I am a widow. I belong to the madiga community. My husband died when my daughter was two years old. I was young then, only sixteen. I had been married as a child.

My mother lives with me and is a great support and companion to me. We toil hard doing coolie work. I got my daughter married when she was thirteen, as I couldn't look after her.

Usually, Sathyamma was quiet. She spoke selectively. She was always precise and could grasp even difficult concepts. She maintained her fertility charts neatly and accurately. She would share the knowledge with women in her sangha.

Sathyamma's mother died during the training period. This was a shock. She longed for the lost companionship, and took months to recover from her grief.

Every time we did self-exams with speculum, Sathyamma had some or other excuse. Either her periods had just started or they were not yet ended. After much coaxing and convincing, she did self-examine and discovered a heavy infection. We couldn't understand. Sathyamma told us she had no relationship, and we believed her. But, as the infection didn't clear up inspite of treatment, we had to ask her directly. Nagamma asked her,

Tell us what's wrong. In front of us, you need not be ashamed if you are relating to somebody. Haven't we shared our lives with you? You are young. Your sexuality must have some scope, after all.

This took place around the sixth month of our course, and Nagamma loved using the new concepts she had picked up. Slowly Sathyamma confided that she had been meeting someone quietly outside the village, but had not shared this with anyone before. At this juncture, she expected us to say,

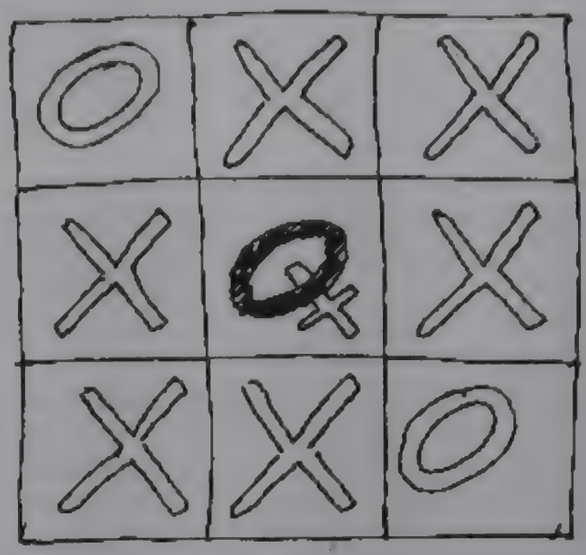
You're a widow...how can you do this?

But the group was sensitive. We tried to explain that she has to protect herself. She must not allow herself to be harmed or exploited in this relationship. She must talk to him, get him to take treatment and persuade him to use a condom. Three months in a row she examined herself - the infection cleared up. She said she had taken condoms from our training centre and he had used them.

At the end of the first year, Sathyamma was thrilled to collect the self-help kit. It was a small trunk packed with all she needed to help women. She literally clung to it. Any free time, she would check and re-check if all the *samaan* including speculum were intact and in place. Having skills in hand made her feel secure. Now she was someone. She could write her name, read bus signs, posters and small sentences. She said,

Now no one can call me 'unpad' (illiterate) anymore!

Vasantha



Vasantha was a young activist whom we had met at a survey-study workshop in Hyderabad. When she heard of the self-help training, she wanted to be a part of it. Inspite of her urban background, we agreed to Vasantha joining us.

I am Vasantha. I am twenty-six years old and have completed my BA. I live here in Hyderabad and have been brought up in the city. In my college days, I belonged to the students' movement. Some of us friends have got together, and we visit two slums. We try to help out the women with their problems. I wanted to take up computers, because I badly needed a job. When I heard of this training, I felt that I may get a skill, besides, I was also interested in health.

I married four years ago. My husband is just now completing his PhD in English literature. Because of polio in childhood, he is disabled and uses a wheelchair. My parents were against our marriage, but we went ahead. My mother-in-law is very good to me. She supports me on various issues. My husband, too, is a good person. He is supportive and helps me with English. But at times he is possessive.

I am quiet by nature. I have little confidence to talk in a group and get intimidated easily. Then I retreat into myself. I need to build a career, but I don't know where to start. Because of this, my husband and I have decided not to have children just now. For the last four years we have used 'natural family planning'. Sometimes my husband uses a condom.

Inspite of not receiving the stipend which the sangha women got, and not having a regular job, Vasantha kept on and completed the training. In

the group she was well accepted. She interacted with everyone and looked out for whoever needed more explanation. Because of her non-project status, she could solve misunderstandings and keep the group together. She helped us compile our reports in Telugu.

In the course of the training she decided that she would not like to use 'self-help' skills to earn a living. Promptly, she enrolled herself in a B.Ed. course to become a teacher. Side-by-side, she keeps looking out for scope to share self-help training with others.

Vasantha has a lot of interest in Fertility Awareness. When she learned Mira would be in Tirupati for the National Conference of Women's Movements, she carried her fertility awareness charts there to show them and get her comments.

Vasantha was not very strong. She would come every month with a cold, cough, fever, ear-ache or head-ache. Antibiotics sometimes gave temporary relief. The foods in our diet at the centre seemed to help her, and she tried them at home. She completely switched over to herbal remedies. She became stronger and healthier than before.

During the training, Vasantha gained confidence. She was good at thinking analytically but was not articulate. She now forms opinions on various issues, voicing them without hesitation. She says the training helped her as a person.

Sivalakshmi

My name is Sivalakshmi. I was married when I was twelve and immediately sent to my husband's house. My husband related to me even before my periods started. I conceived after my first period. I knew nothing about periods, and I didn't know I was pregnant for a long time. Then, I didn't tell anyone until it was obvious in the eighth month. I gave birth to a son.

My husband had three brothers, and they had lots of problems among themselves. There were fights everyday over property. One day, my in-laws themselves poisoned my husband and he died. My son was only six months old then. During the funeral rituals, when the women were bathing me, they realised that I was pregnant again, three months. My in-laws wanted me to abort it, but I refused. My father-in-law was worried about the property. He said,

Now that you are a widow, why should you bear a child?

But, I went through the pregnancy, and my second son was delivered in a hospital. They asked the doctor to operate on me. I was only fifteen years old. I fought against it and somehow escaped the operation. My in-laws harassed me. They said,

You're a widow - you should be ashamed of having this child. You know you can't relate with any man now.

My father-in-law insisted I have my bath only with cold water. Always, I was given curds and rice and nothing else to eat - no spices, no chillies, no pickles or chutney for me! Even now I have the same diet. This is how they tried to crush my sexual desires. Allowing only bland food, making me work 'til I'm dead tired, sleep on the cold floor, cold baths always, dull white saris to wear... Even after all this, I have lots of desires, but I'm scared... What will people say? What will my sons say?

I have to fight a lot with my in-laws. My sons are grown up now - they're on their own. My in-laws refused to give us a share in the property. They'd taken a loan on the land, and they said if I wanted a share then I'd have to pay eleven thousand rupees. I worked hard and paid the loan, so I got this small piece of land. I am alone. I have to fend for myself. I earn my living by working as a coolie on daily wages.

Is there any way for me to satisfy my sexual desires? My sons won't let me get married, but still I have cravings. Look at me - when I came here, you all thought I might be fifty, but I'm only thirty-six! I'm sick and tired, but inside my spirit is young.

Sivalakshmi is from a village in Vishakapatnam District. The training was like opening the shutter

for a caged bird. She found space to talk, to explore friendship and to live for few days without restrictions. Slowly she changed her way of dressing, choosing brighter colours which had been denied to her. Every time she returned to her village she faced criticism about the training.

When Sivalakshmi discovered that sexual intercourse was not the only way to satisfy her physical urges - when she learned that she could give herself release by fondling her clitoris to orgasm - she told us about it with a deep sigh of relief. It was revolutionary for a woman who had suppressed her sexual urges right from the age of fifteen. We gave her the safe space to tell about her experience, but we warned her about sharing in the village - to be discrete and selective.

But, no, for Sivalakshmi it was a major discovery. She spoke about it to other single women. She even shared her discovery at the sangha meeting. Imagine the reaction she got, but it didn't stop her!

Sivalakshmi's grasping power was limited. Beyond her major discovery, she simply could not relate with other aspects of the training. Also, she had poor eye-sight. Early on, we had noticed that she held charts upside down often, but we realised it was an eye problem only during the speculum self-examination. The demands of the course had become a constant strain on her. In the sixth month, as a group we decided to let her discontinue.

Ravalamma

During our visit to one of the projects for selection of participants, we were driven for six hours by tractor to a tribal village tucked far up in the hills. There was a meeting with the men and women there. No health services ever reach this place. The people's spirit and friendliness tempted us to pitch our tents, but the self-help training was scheduled to start. The women selected Ravalamma. Small-built, lively, talkative - her eyes beaming to take in information - Ravalamma joined our group. She was around thirty years old.

I am of the Enadi tribe. It is said to be a criminal tribe. All the time we have lived under the protection of some caste landlord to whom we pay a heavy price. Even now in the hills, we work as landless labourers for six rupees a day. I am married and I have two children.

My husband is cruel and has treated me badly all these years. He beats me and tortures me. Sometimes he goes away and lives with another woman. I am so happy at these times, as my body gets rest. Even now sitting here, I can feel all the pain he has caused me. One day he took me to the forest, tied me up to a tree and pushed a bamboo into my yoni because he was not getting enough pleasure from me. My yoni is too small, he said. Often he has tied me up to beat me.

Now my daughter is married, and she and her husband live with us. I don't like my husband beating me in front of them. The worst will be if my son-in-law starts to do the same to my daughter. Besides, I feel ashamed to be treated like an animal. I'm afraid of going back after the training. Here, I'm treated like a human being. Everyone is so concerned about me. After all that I am learning here, will I still be able to tolerate all the suffering and keep quiet?

I can get angry. What if I raise my hand on him? I am strong, and I, too, can beat him up! But all this time, I have held back from it because of the others. Men would call me a bad woman, or they would call my husband a weakling unable to control his wife. Although Ravalamma had suffered a gross degree of torture, we understood her dilemma. We gave her time and we listened. We suggested to her that she doesn't have to take his beatings. Here is what happened when she went back after the Gender Sensitisation session.

My husband came all the way to the mandal headquarters to take me home. I was happy about that. On the way, he asked lots of questions about the training. I told him what we had learned. Half-way home he stopped for some arrack. Then, he started abusing me, calling me a prostitute. I kept quiet and we reached home, late in the evening.

Still he kept on, and then I answered back. He got angry and hit me across my face. This was enough. At that moment, in my anger, I decided to do it now or never. When another blow landed on my back, I gathered my strength and I slapped him. He was stunned. He couldn't believe it. I told him to get out of my house,

You can go and live with the other woman. I don't need you!

He kept quiet and went off. The next day when he was sober he returned. He asked me to go with him all the way back into town to meet our woman organiser Lakshmi Narsamma. We went, and he complained to her about me. But Lakshmi Narsamma is in our group and knew my story. On our way back from Hyderabad, she had encouraged me. She forced him to admit his fault. I had kept insisting that I didn't want to live with him, and I was so surprised when he said,

On no account am I going to leave you. I will not go to the other woman.

I realised what a fool I was. If I had done this long ago, I wouldn't have suffered so much. Deep down, men are cowards. They will make us suffer as long as we take it. But equal up to them, and they are helpless. They need us to fulfil their needs. They get violent for no real reason. I didn't want to be violent like him, but I had no choice.

Ravalamma needed assurance that what she did was alright, and we gave it.

After just four months, Ravalamma was forced by circumstances to discontinue. She was accused by the police of being connected with a political group taking shelter in her village. Because of this, she had to go into hiding. The project has no further news of Ravalamma, despite Lakshmi Narsamma's attempts to find her.

It was a real mishap for such a promising participant to be lost from the training, and distressing for our group.

Saroja

Saroja was our youngest participant.

I am eighteen years old. I have never been to school. I work in the fields and do the housework, too. I got married when I was fifteen, but then I loved another boy. My parents didn't approve, and made me marry my father's sister's son. My husband's family has a lot of property.

We lived together for six months, and we were happy. Then one day at work in the field, he was attacked by a bear. The others couldn't do anything, and he died. When they came and told me, I was shocked - I couldn't believe it. Suddenly I was a widow.

My mother-in-law ill-treated me - she is also my aunt. They don't want to give me my share of the property. I have come to live with my parent's. My father has spoken to my aunt many times, but they don't want me back. In our caste, I can't remarry. I want to have a son - tell me, how can I have a child? I want to get my property back. I was three months pregnant when my husband died, but because of the shock I miscarried. I do have sexual urges. Many young men get attracted to me. Why do people only look at me as a widow? Don't I have a future?

Saroja was visiting Hyderabad city for the first time. Never before had she been to the local town. Coming to the city had an effect not only on her but also on the village women. On her return, they called her 'Doctor Saroja', and shy and timid Saroja became assertive!

Somehow, Saroja developed interest only in dispensing medicines. She collected packed herbal remedies which Pushpa used to bring each month

to our training centre. For stocking her bag, she selected only what she thought would give her recognition - powders and tablets already prepared. Roots and leaves for decoctions were not her 'cup of tea'.

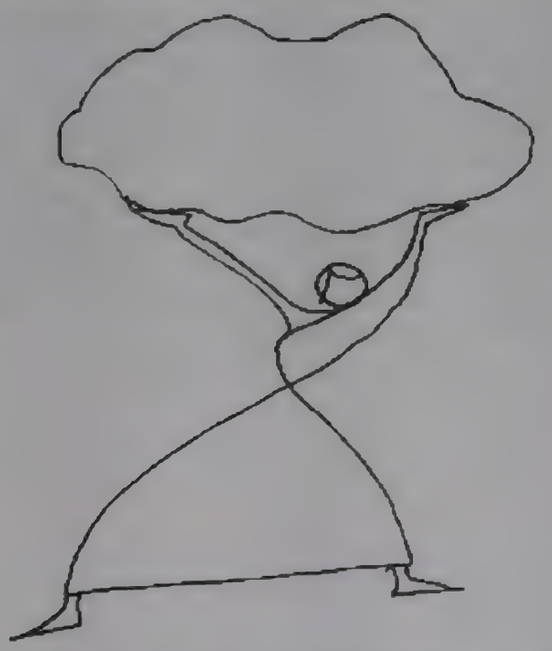
She was bright, but she didn't care for the content of the training. Neither did she take interest in literacy. She didn't care about learning fertility awareness, or other self-help skills which might really have helped her. She didn't even try to understand the process of menstruation. All our innovative attempts to engage and teach her failed. Even back in her village, as she was so young, women hesitated to go to her when they needed help. So, we tried preparing her to work with teen-age girls. This too failed.

But Saroja did not want to discontinue, either.

She dreamed of becoming a 'doctor', and attended the training for a year. At that point, we realised it would be difficult for us or the project to answer for her actions. Self-help requires being sensitive to women, to reach out to others as equals - qualities she had not developed.

After pondering over it with the group we decided, and asked Saroja to withdraw. She was bitterly disappointed. Now, she is involved with her local sangha in other ways.

Parvathamma



A harder life than Parvathamma's is hard to imagine.

My experiences will make you cry. I have struggled through it all, and what I am today is because of my beliefs and courage.

Both my parents died when I was very small. My relatives arranged my marriage when I was only five years old. My husband was much older. Hardly had I been married two years when he died. I don't know why.

I grew up as a child widow at my husband's house, and got my first period when I was twelve years old. There was no celebration like other girls had. I missed my mother very much. My periods gave me a lot of problems. I used to get a heavy flow and a lot of pain. They didn't come every month, but once in two or three months. I was not taken to any doctor.

I had a very hard time at my husband's house. I had to make lots and lots of roties and take the bundle to the field and feed all of them. Myself, I hardly got anything to eat. At night, when all would eat rice, they would give me ambil (thin fermented cereal gruel) to drink. Sometimes they would completely starve me. I had to wash the clothes of my father-in-law and brothers-in-law. I had to massage them before they fell asleep at night. But they wouldn't allow me to rest. I had to sleep sitting upright.

I was blamed by all for my husband's death. Once, as punishment, I was given my father-in-law's urine to drink, and I was made to sleep on a bare rock outside in the cold. All this hardened me at a very young age. One day in a desperate situation, I just walked out and went to the house of one of my maternal relations.

I started going for coolie work, but my wages were used up in my relatives' home. Here, too, I had to work for all in the family. They got me married again. For four years, I lived with my second husband, but I didn't get pregnant. I was pressurised to bear a child. I was not taken to any doctor to see what was wrong. Instead, all blamed me. One day my husband just left me and went away. He has never come back. I believe he is living with another woman.

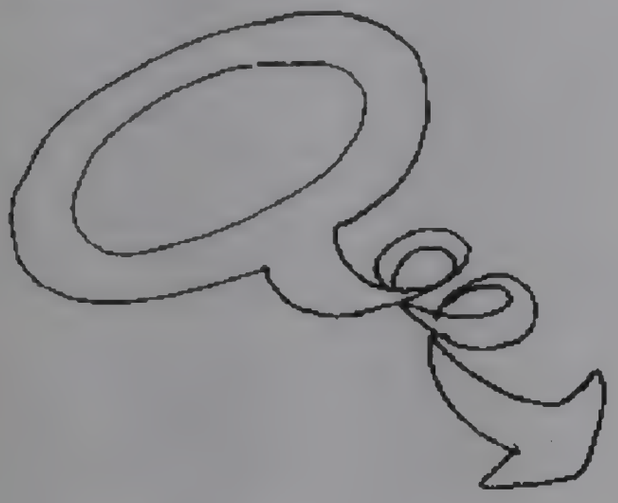
Since then, I am alone and I work as a landless labourer. I am happier, but living alone there are other problems. No one cares whether I have enough to eat or how I survive. But, if they see me moving outside the village, or they hear me speak, they question me. That way, I have to answer all in the community.

Parvathamma is strikingly beautiful but hardened. She gets angry fast and yet she cools off just as fast. After all she has gone through, how much can we expect? Starvation in childhood has left traces - her mind is slow to grasp, and she finds

security in her traditional beliefs and values. What appealed to her most during our training days were the exercises, songs, games and dances. The demands of the sangha women on her to share the training was too much for her. Besides, survival was her priority.

Parvathamma herself dropped out after the fifth month of the training. She continues to go for coolie work, and she stays active in her women's sangha.

Lakshmi



Just six months before our training began, Lakshmi joined her project as a woman organiser.

I am new to development work. I don't have experience.

I belong to a brahmin family. My father died three years back, and I live with my mother and my married brother. My father left us enough property, but the fruits of the land are enjoyed only by my brother's family.

I am not interested in getting married soon. I am only twenty-two, and I want to work and look after my mother. But my brother is keen for me to get married and leave. He doesn't want to share the property. Sometimes, I myself wonder whether I delay my marriage because I want my share of the property. My mother has no say about it.

Two years back a big lump grew in my breast. It was an abscess and had to be cut open. Still there is a deep hollow which oozes. I have painful periods, too. In the six months since I have been working, the project has shifted me twice to different areas. The moment I got accepted in the community and was getting along well with the people, I was told not to develop friendships. My project leader is a woman, but she doesn't understand me.

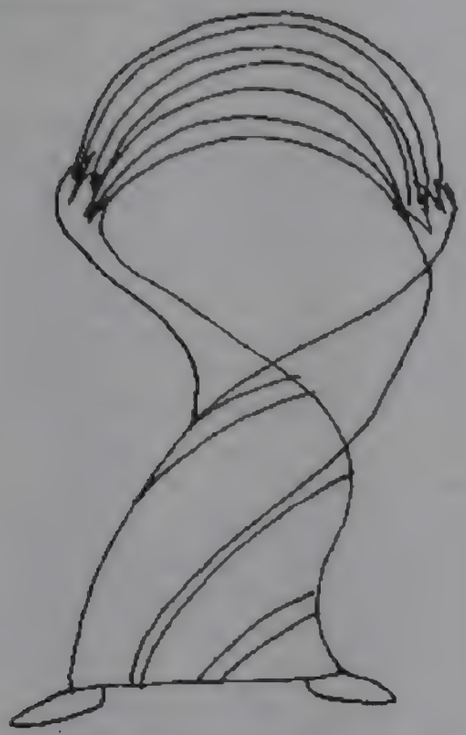
Timid and self-conscious, Lakshmi's good looks and young age had been a disadvantage. As the training progressed, you could see her open up. When we did breast self-exam, she cried about her abscess scar and the hollowness. For a long time, she literally shivered.

When she overcame her fear, she changed. She lost her deep inhibition about her body and gained confidence. She started pinpointing and answering back to injustices done to her at her project. A time came when Lakshmi's project leader asked her to discontinue the course as she was getting 'too assertive'. She replied that she would travel to Hyderabad on her own.

While travelling by bus to Hyderabad, a man sat behind me. He kept touching me every time I fell asleep. Normally, I would have kept quiet, not wanting to create a scene. But after our session on Violence and Body Politics, I didn't want this man to have his way and go free. So, next time he tried touching me, I reached back and caught his hand, and I twisted it so badly that he yelled. Then he got embarrassed, because the people in the bus found out what he was up to. In the morning there was no sign of him, for he had got down before daylight.

For Lakshmi it was a losing struggle. During the days she spent with us, she would bloom and be full of life and new ideas. But every time she went back, her initiative would be crushed. After eight months, Lakshmi could no longer take it. We don't know exactly what happened. We couldn't contact her as she no longer stayed with her mother. She left the project and discontinued the course. Recently, we got news that Lakshmi is working with another project.

Ramalamma



Describing Ramalamma is not easy. One has to meet her. She is a talkative, expressive woman of about thirty-five years - child-like, innocent, playful, loving attention. As she sees it, her life has been smooth.

My husband cares for me. He has taught me a lot of things. I was very young when I got married. I thought love was just dressing well, making myself beautiful, dancing and singing together like in the cinema. But when my husband started relating to me, I got quite upset. What he did hurt me a lot. But he was patient. One day he took me for a cinema show. There were love scenes. I was feeling shy and closing my eyes. My husband nudged me and said, 'See, that's how you should love me!' He spoke to me about having sex, and I began to loose my fear.

Ramalamma belongs to a women's sangha in a village of Anantapur District. She was selected by the project. As she had never travelled beyond Anantapur, coming to Hyderabad was a big step.

Ramalamma was the funniest in the group and kept us in splits with her jokes. But, she found reading and writing work extremely difficult - she just could not make headway with it. While strong on her old ideas, she was slow to grasp new concepts.

Every month, Ramalamma would come back to the training centre with lots to share about her family and about the other sangha members.

Once she said,

When I returned last time, my husband was suspicious. He asked a whole lot of questions about the training - what all have we been doing, who teaches us. I told him about the exercises we do every morning and how they help me relax. Also, how the session on the Body has made me aware, and now, how I care for my body and how I watch it's changes.

He asked whether there were men around, especially at night. I told him there are no men, only we women. He even asked whether our classes are video-taped. I don't know how much he believes me. He said he intends to come to Hyderabad to see for himself. Akka, will you let him stay at the centre?

Ramalamma liked our morning exercises most. She loved singing and dancing, too. She took back exercises, new songs and dances to the sangha women.

Our village is full of drudgery. Even after working hard there is always too little. So, when I get the women to dance and sing, it livens them up and makes them forget their miseries.

After having been with us for a year, Ramalamma and Nagamma could not continue. Lakshmi, the staff participant from their area had left the project. They were not allowed to travel alone to Hyderabad.

Nagamma

Nagamma belongs to the *lambadi* community, once a nomadic tribe. She comes from a small *thanda* (settlement) in Anantapur District. Like many lambadi women, Nagamma is outspoken

and robust. She says she is around forty, but her youthful bright face seems to say she is less.

My mother had twenty children, and eleven of them lived. When I was expecting my second child, my mother was pregnant too. She was ashamed. But, I remember my brother telling her,

'Mother, why do you stay indoors? You haven't done any wrong. So what if you're pregnant - we like you like this!

Even now my mother is healthy and active. I don't remember her falling sick. The food when we were small is no longer grown. Today, all the fields are sown with groundnuts and sunflower. No more maize or ragi. I have five children, but I don't feel as young as my mother. My life has been comfortable. I can't recall any oppression or harassment in my life.

As the training progressed, Nagamma began to withdraw. She was thoughtful. We wondered, what could have happened? One day she looked up and said,

I want to share a small experience of mine - I felt used by my husband. I went for tubectomy operation. No one forced me. Many of us went on our own because we women feel it's alright to have sex with someone if we want, not that I do like that. But, we don't want to get caught carrying his child.

After the operation, according to doctor's instruction I was supposed to rest and not relate for two months. My husband agreed and for two months he never came near me. But, as soon as two months were over, he started forcing me to have sex. These were the words he used, rather he demanded,

I want to see your mirror- show me your mirror!

I understood what he meant and let him have his way. I don't know the reason, but as soon as he was done, I started to bleed. He saw the blood coming out and got frightened. Right away, he took me to the doctor. From what he said to the doctor I found out he didn't care for my well-being. He was worried about who would take care of his children. And if anything happened to me, he wouldn't be able to have sex with me.

This was such a disappointment. All this time I was under the impression that my husband cares for me. But here was a clear sign that he worries only about himself, his sex needs being satisfied, his children being taken care of.

Now I recall a hundred other incidents - how we women are used day-in-and-day-out, in a very nice way. Especially us who are wives, we feel that everything is love, and everything in love has to be given, but we don't realise that our giving is one-sided!

Nagamma never went to school. Because of what she learned and practised during the training, she can now read slowly. She took keen interest in the literacy class. When we made it optional, she kept at it. She was quick to grasp technical information. She enjoys showing she can use words like 'estrogen' and 'progestrone' when explaining her fertility charts. Awareness and knowledge of her body was empowering for her.

Nagamma shared an incident from her village.

A group of men were absconding because of a charge that they had robbed. At sunset one evening, a police van came and arrested their women relatives. On hearing this, I rushed to the van and challenged the sub-inspector,

How can you arrest women after sunset? You have no right. What have the women done? If the men are accused, catch them. Women aren't responsible for men's actions.

The sub-inspector was angry and questioned the people around,

Who is this woman? Where has she learned all this about the law?

She attends a training in Hyderabad, they told him.

What sort of training? he asked furiously. But I didn't give in. Some more women joined me, and we blocked the van from moving. Then I said, Come in the morning if you want to question the women.

After arguing for some time, the sub-inspector left. I felt very proud. This incident has given me recognition in my thanda. Now even men come to me if there are problems in the village.

A small input on legal literacy after dinner was all Nagamma had been exposed to, yet as we can see, the effect was powerful.

Because of her husband's demands, it has been difficult for Nagamma to attend the training every month for six days.

My husband is afraid that men in the city will get attracted to me, and I may leave him. He gets upset every month. I have people at home to cook and all. I do the weekly marketing before leaving for Hyderabad.

Every month when I'm about to leave, he says,

In Hyderabad there is big bazaar. Don't go anywhere near it! You're a lambadi woman, so take care. But every time I come away from my house, my mind is still there. I Keep wondering what my husband could be doing. At night, I can't sleep. He has strong sexual urges. Ever since my operation, I don't crave for sex any more, and I feel tired. He wants it again and again. He says the problem is I'm weak, so I should eat more and become strong.

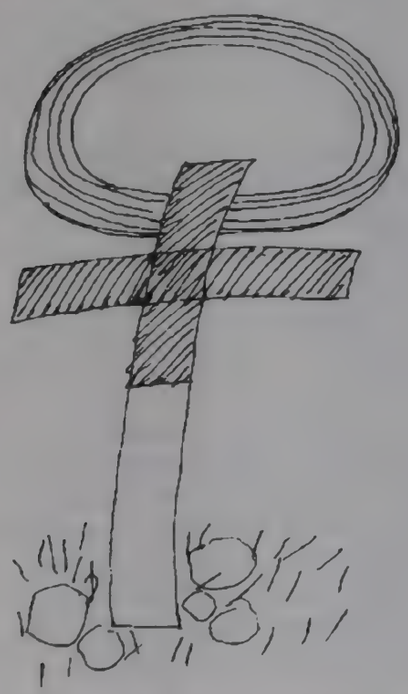
Now I'm here. He might go to another woman. He might not be able to wait for me to return...

During the training, Nagamma got stronger. We looked forward to visiting her village. But, when we landed up there, we had to look all over. We thought Nagamma would come running at the sound or sight of the jeep. By asking the children we reached her home. She greeted us tensely and took a few moments to show a little warmth. We noticed her husband sitting and glaring at us from the shop next door. He didn't speak to us.

Later, Nagamma told us that she has been taking more decisions in the family and saying 'no' if she doesn't want to have sex. For this, he was angry. He doesn't like the women coming to see her.

Now that I have started the mahila sangha, we sometimes discuss late into the night which annoys him a lot.

Sabala



I chose the name *Sabala* myself. It means *strong, independent, 'empowering'.*

I was born in Bombay - the eldest of six children. My father was the only wage-earner. Every month my mother struggled to make ends meet. All eight of us lived together in a small room. I hated our poverty, but it has helped me understand and work with those still more deprived.

I could never bear injustices, and always fought for myself and for others. Early in life I found that justice doesn't come forth equally for girls and boys. My sisters and I were restricted, but not my brothers. Envious of the boys' freedom, I wanted to be a boy. I tried acting tough like them. It wasn't easy to accept being a girl.

After high school, my education was stopped, and I had to join a secretarial course. *What use is education for girls?* my father said. No sooner had I started working than I faced my parents' pressure to get married. *Staying single won't do - What will people say?*

I had the option of joining a convent. Despite the vow of poverty, life there turned out to be far more comfortable than at home! I just had to obey, and never question my superiors. All would be given to me, but I should imagine that I was living poor and deny my sexuality.

Very soon, I began to detest this life of privilege and pious thought. Yet, for sixteen years I kept on thinking that things might change. During that time I learned a lot, it is true. I studied and became a nurse, and I got work experience in a fully equipped modern hospital. However, the experiences of working in the community for the last so many years has de-schooled me of my nursing education, of my moulding in the medical system.

In 1974, there was a shift to focus onto problems of the poor. I seized this opportunity and asked for a change from the prestigious hospital. I was sent as a public health nurse to a rural area on the outskirts of Bangalore. My job was to train other nurses and to help re-design a village health project. Later, Kranti joined the same project. The two of us then worked together in rural Andhra Pradesh and Maharashtra. In each state we were associated with an NGO organising landless labourers in dalit and tribal communities.

In 1981, I was called back to the convent, and I had to make a choice.

Must I leave my work in the villages and return, or should I disobey authority and continue?

With this choice forced upon me, leaving convent life for good was not difficult. After that, Kranti and I set out on our own as trainers and consult-

ants for a variety of development and health projects all over India.

Once out, I didn't want to depend on anyone. Yet, starting to build a new life at such a late stage and as a single woman in society has not been easy. My singleness is looked at with suspicion and doubt. My family and others think that, since I'm single I have no other responsibilities, so I'm expected to be available and to have answers to everyone's problems.

Singleness has brought me in touch with other like-minded women. These close friends have become my extended family. My happiest moments have been with small groups of women - exploring, sharing, trusting. And, it has been joyful to live and work with Kranti.

Kranti

Today many know me as *Kranti.* Since my name means 'revolution', sometimes people remark, *Your mother must have been radical!*

But this isn't so - I'm from a conservative patriarchal christian family! My mother is subdued. Even today, at the age of seventy-six, she bows to my father's every word. My two brothers are the oldest and youngest among five children, with us three girls between. Unlike my sisters, I was a rebel. Sandwiched right in the middle, somehow I asserted myself and defied the norms.

In our family, the boys were always favoured. Their power over us frightened me. In my own and my friends' lives, I saw and endured oppression of girls and women. A cousin my age became pregnant and was sent off to a home for delinquent girls. She was labelled 'bad', and I was forbidden to visit her.

In the late seventies I opted to work in rural areas. This was my first exposure to real poverty and simple living. It refreshed me and opened new avenues. It was there that I began working with Sabala.

In the villages, it felt foreign to use my given name *Jeanette*, so readily associated with christianity. I was puzzled about my identity. At a women's workshop in 1978, a friend gave me the name *Kranti.* She said I don't talk much, but my silence speaks louder than words. I liked the name - it reflected a feeling I had about myself.

I experienced sexual abuse as a child and right through life. If you are single, men feel you are available, not accountable to anyone, so they try to claim a right over you. I have dreaded working with men. They have never respected me, never treated me as an equal - be it my colleague or my in-charge. A single woman has no right to live her own life. Society eyes her with suspicion, questions her every movement. One is never free to travel without experiencing unwanted touches. When men stare in a certain way, I feel like I'm being raped.

Now, Sabala and I live in a flat in Bombay. Some of the neighbours raise their eyebrows, and speculate about our life.

But, my feeling of singleness is not negative. It gives me independence, the freedom to decide for myself, not being tied down to family responsibilities. It is a kind of lightness. I can relax. I love to cook, but I cook when and for whom I want. I go to meetings late in the night. It's true, I get nervous out at night, but I think of the slogan, *Take back the Night!*

Experiencing the self-help training process has been a radical experience. I had to share my-self and my life choices. I had to uncover a lot of inhibitions and release a lot of restraints. It was the first time I looked at my body - that, too, in front of other women. Once I had broken my culture of silence, and turned down the volume of do's and don'ts in my head, I felt greatly liberated.

In the Name of Love, an Ocean of Oppressions.....

These are real lives - not fictions. They touched all of us. The process of bonding had begun. We guided the group to learn from each other's experiences, but to avoid getting lost in anyone's suffering. Through collective experience, each was expanding the vision of her own life.

The greatest openness seemed to come from women who had suffered the most. As we rolled with the waves of unfolding stories, the ocean of oppressions stretched out before us, from torment and torture to the very denial of existence. They told of suspicion, discrimination, threat, cruelty, suppression, exploitation and deprivation - often in the name of 'love'.

They also told of strengths and courage. Despite terrible experiences, most of these women had a positive outlook on life. They took happiness from simple events, like celebration of their first menstruation, marriage, birth of a child, visits to parental homes. And some had put up stiff resistance.

The sharing went on late into the nights and took almost half of the first six-day session.

Considering all of our varied experiences, it was not difficult to get sensitised to our plight as women. Despite our different backgrounds, there was something of the harsh experience of living a woman's life that all of our stories told in common.

Still, we needed to reach the insight that,

> *whatever happens to us is not because of the biological fact of our birth in women's bodies, but because of a socially constructed set of rules thrust upon us.*

3

Phase One : The Training

Through this training we sought to break a path away from the general trends and attitudes which we all had been steeped in up to this time. Collective experience was central, yet we encouraged listening and learning from the experiences of each woman.

Before getting immersed into the content of the training, let us tell you something more about our approach, how we have organised the content, and the resource persons who helped us.

The Self-Help Outlook and Approach

Our particular approach to 'self-help' training has evolved from our experience. It embodies values we have gained from both the *socialist* and the *feminist* streams.

The feminist movement gave us important new ideas -

- *the personal is the political*
- *strength in diversity,* and
- *creating space.*

Self-help theory and the practice of *women's health-work* has developed along with these ideas.

⇒ The first idea challenges the dualistic belief in an outer ***political*** world and a private ***personal*** world. This is a 'male-structured' view, where women are seen as part of men's private personal zone. Women are supposed to have nothing to do with politics, living merely to enhance and support men through their unquestioned roles at home or at work-place.

Women's *experience*, however, tells us differently - that real politics is very much alive between women and men, men and men, between women and women, and between parents and children, in the family. Besides, these very power relations form a pattern for relations in society !

⇒ The idea of ***diversity*** values the vast resources that women have - that human beings have! It holds dear the socialist idea of unity and solidarity, but stresses that to stick together, *people don't need to be the same.* From diversity flows the idea of *equality* that recognises differences.

It also leads us to challenge *society's ideas of 'normal' and 'abnormal'.* In men's world, even *being a woman* is abnormal! Men allow women a feeling of being relatively normal if they are 'good' women. To avoid being declared deviant or 'bad', women must abide by the males who dominate them. Feminists feel solidarity with all persons marginalised by so-called normal society, whether on the basis of sex, poverty, caste, tribe, religion, age or disability.

Appreciating diversity, we bring to the fore our whole baggage of personal and political identities and our differences, which need to be respected. Especially today, when women pay the price of communal violence and our groups threaten to break up on religious pre-texts, we have to recognise and make space for diversity.

Strength in diversity need not be threatening, so there should be few reasons for competition or hierarchy. *Co-operation* and *non-violent ways* of working things out ought to be a sensible and natural path.

⇒ The feminist idea of ***creating space*** enables us to freely express and appreciate our diversity, to live joyfully, and to evolve a different, *positive* kind of politics. In such spaces, we re-claim what we have lost, and we build anew. Breaking away from oppressive myths of normalcy and dependency, we develop self-esteem and confidence, and learn skills of mutual support. We discover *autonomy* and collective *empowerment.* We work towards social relations that are non-hierarchical and non-violent.

Creating space is one of the dynamic ways women can bring about changes. We begin changing 'right here' and 'right now', in the spaces we make for ourselves. And, we care-fully work at expanding and linking our spaces in participative and democratic ways.

In our training space, we tried to coax out the diversity among the participants and us. We broke the divide between public and private - politicising the personal while personalising the political. We took a hard look at society, including subordination at all levels, understanding power relationships in homes, at work-places and in communities on the basis of gender, class, caste, ethnicity and so on.

We have adopted the concept of *Gyn-Ecology*. It is radically opposed to 'gynaecology', the standard outlook of 'women's diseases' connected with the womb and reproduction only. Gyn-ecology is *women's total health in balance*, crossing the limits of women's bodies into society and back. Even now, we feel there is much conceptual tidying-up to be done, but we had to tell ourselves, it is not the work of this book!

Content and Methodology

The *content* of the training was planned carefully according to needs of health activists and was based on their experiences. We tried to achieve a balance of building analytical understanding and practical skills.

Although we have organised the *sequence* of the chapters topic-wise, the training process was not compartmentalised. The topics were inter-linked and inter-twined. In all of them, the politics of class and gender emerged.

Methodology was participatory and process-oriented. Even so, it needed a lot of preparation and planning. We spent time and effort in planning visuals, stories and games. We could never be rigid about the plan. It needed flexibility and sensitivity to the group's environment. Sometimes, we could not introduce a content and methodology that we had worked hard to prepare, because the group was not ready. Training is always a two-way process. Just as we have shared our information with them we too have learned much from the group's experiences and knowledge.

The Resource Persons, and Us

We consciously selected resource persons who have been part of the women's movement. We wanted the participants to interact with other women activists. We were confident that they would use a *feminist approach and methodology*.

Vasanth and *Volga* helped with Gender Sensitisation and set the overall perspective for the training. They revealed how closely women's health is inter-linked with gender discrimination and violence in the family, the health care system and society at large.

Mira helped us with Fertility Awareness, linking it with sexuality and enabling the women to observe and record their unique fertility patterns. The two days together with her were exciting for the group, and her interest continued throughout the training. At the end of the course she sat with the women to analyse their charts and understand the variations.

Sarojini facilitated the session on Self-Help and Self-Exam. Her friendly and relaxed way and her fluency in *Telugu* put the women at ease, so that not only did we lay down our inhibitions but we learned the self-exam skills on our-selves and each-other with confidence.

The resource persons introduced the fundamentals, and we developed these topics further in our group throughout the training.

All the other sessions were evolved by the two of us together with the participants. We were *all* resource persons with a wealth of experience. The women allowed each-other to come into their lives and they constantly enriched the process. All of us in the group provided 'live visuals', better than any chart! Most of the herbal remedies we used were generated from within the group.

Communication with the Project Partners

Throughout the training phase, we kept up our contacts with the project partners through letters and visits to the projects. We informed them regularly about the training progress and developments in the content.

Right through the training, we were keen to follow how the participants would be integrating the 'self-help' experience within their project setting, among their team members. We wanted to know what impressions the other staff were getting, and whether the support systems were working. On our visits, we attended sangha meetings, considered problems of local women, were available for our participants, and met with the project partners and staff. We listened to their impressions and, along with them, tried to work out solutions to problems that arose. And, together we all planned the second phase follow-up, including 'women-and-health programmes' and 'women's resource centres'.

Re-Claiming and Acquiring Skills

'Skill' in itself is an important issue for women. The basis of women's self-help practice is building and re-claiming skills. Women are prevented from learning certain skills, and traditional skills are increasingly being taken away from them.

Skill is the ability to transform and recreate situations and relationships which help us find solutions and come to decisions.

Sensing how important ***literacy*** would be to self-help, we set aside time for it. The project women took responsibility to teach the sangha women and to prepare visuals and literacy games. Soon we saw that literacy was taking too much time out of the six days we had together. Despite the women's keenness, it was too big a task to make the group literate alongside the course. It cut down time for discussion, personal interaction, quiet reading and reflection and evening walks. Fun and laughter died down, as we all got exhausted by night-time.

It dawned on us that back in their villages our sangha women were not regularly attending the projects' literacy classes. So, after four months we limited our literacy input and made it optional. Today, five of the sangha women participants can read and write, though not easily. Now that they carry more responsibilities, they realise the importance.

A ***survey*** was needed to assess the specific conditions and health concerns of women in the selected areas. First, we had planned a simple survey for the participants to fill out before the training and bring with them to the first session. Then, to be true to our self-help approach, we thought we should include them even in the survey planning. Learning to do a survey completely would impart important skills. So, we decided to include this *along with the training*.

Scrapping the earlier version, altogether we designed the new survey format. We set the objectives and considered various methods of surveying. We role-played how not to sound threatening or intruding while asking questions, how to observe body language, and how to follow-up gestures and 'unspoken words'.

The survey included collecting data about women and their families, socio-economic conditions, and women's health needs and services. From the survey we intended to draw out guidelines for monitoring the health status of women in the community

The survey was conducted in fourteen villages from the four areas, with about 420 households. After collecting the data, the participants tabulated it with us. They themselves were able to identify discrepancies, and so go back to re-check in those house-holds. Next, we all analysed the data. They went back and shared the findings with the women's sanghas as a basis for planning.

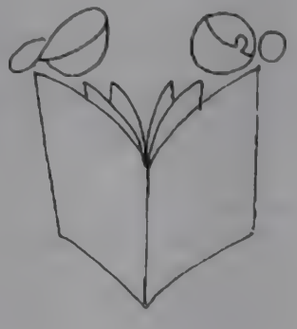
The survey continued as a *monitoring activity*. We worked out ways to up-date the data regularly and to display the findings creatively on the walls of community centres. We engaged the sangha women in up-dating and adding information.

We gave importance to developing skill in ***reporting and documenting***. Our regular practice at the beginning of each session was for the group to select two persons to facilitate, record and write out the *session reports* - there was always *both* a process report and a conceptual report. These were read and corrected by all. Each participant carried back xerox-copies of the reports and a set of *notes and pictorial charts* dealing with the topic.

The skills that we emphasised in this training included

- becoming sensitive and appreciative of each-other and one-self,
- thinking critically, analytically and creatively,
- building confidence in self and others
- surveying and planning,
- recording and reporting,
- 'self-help' health-work skills like 'self-exams', knowing the disorder and healing measures
- individual and collective counselling, and
- communication, collective action and net-working.

We practised dealing skilfully with persons in power in the health and medical system, in the local government and police, and within our projects and communities.



Gender Sensitisation

Politics of Health, and Population

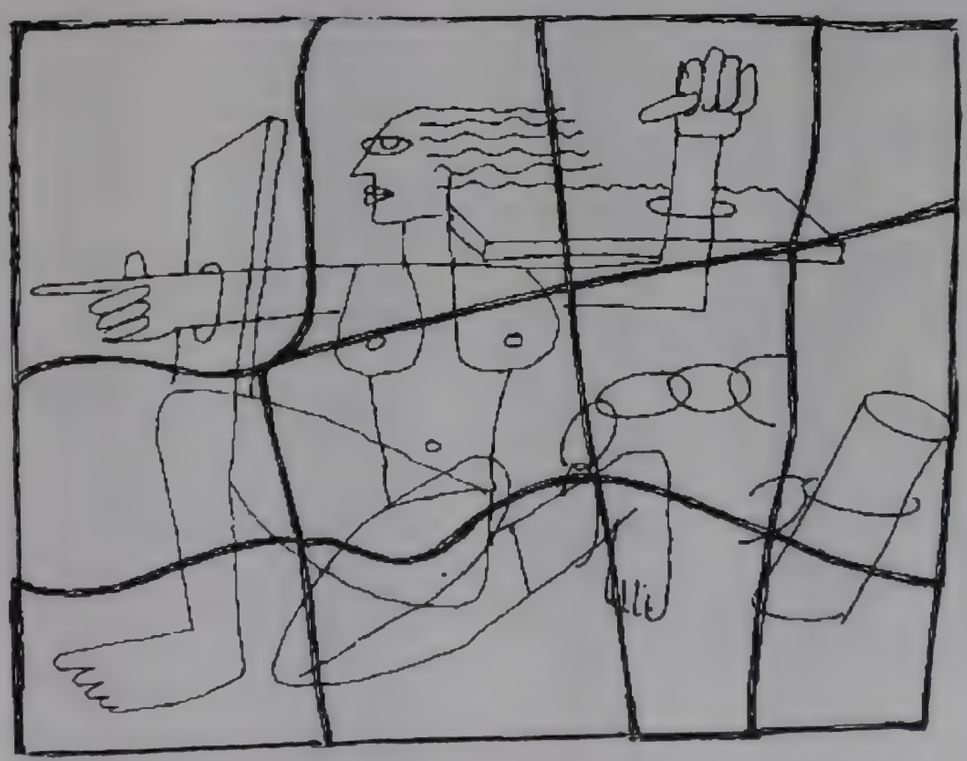
Body Politics and Beyond

Fertility Awareness and Sexuality

Self-Help and Self-Exam

Gyn-Ecological Disorders and Healing

Child-Bearing Support



Gender Sensitisation

Objectives:

- to understand 'gender' and its linkages to power relationships in family and in class-and-caste permeated society
- to identify gender-linked values and stereotypes in our life experience
- to examine forms of violence against women inside and outside the family and its use to keep women in control
- to understand the system of patriarchy and its institutions through which women are oppressed and exploited
- to give value to women's work in family and society
- to learn about the struggles of women to oppose oppression

Methodology:

exercises:	account of women's work stereotypes: good and bad woman. double values for men and women what does it mean to be a woman
stories:	husband deserts wife when she gets barren girl with short hair/long hair
role-play:	boatman and desperate woman
sharing:	women's struggles

In this section we intend to dismantle the myths around womanhood. We give attention to women's experiences and knowledge, which are generally ignored or denied in society. We have just taken a journey through our 'memory lanes' to re-live the experience of being a woman from childhood. Our experiences have become a part of each one of us, carried within us throughout our lives. It is not difficult to get sensitised to our plight as women. Despite our backgrounds being so different, there is something of the harsh experience of living a woman's life that all of our stories tell in common.

Still, we need to reach the insight that

> *whatever has happened to us is a 'social construct', that it is not a biological rule because of our birth in women's bodies.*

There is another dimension. We can easily identify a lot of things that are unfair and unjust, especially outright violence against women. There are many other things that we have never thought about as very wrong, which we never questioned. These things we have accepted as normal, not realising the extent to which society constructs patterns to keep us subservient.

What is Gender?

We first looked at the difference between sex and gender. When we talk about the *'sex'* of a person, it means that a person is born a female or male. So, sex is a part of biology. But one grows up in society to become a woman or a man, and this is *'gender'*. We can understand gender as *a set of ideas* which gets attached to us through stereotyped social images of men and women. To get imprinted by these *stereotypes*, persons pass through complicated socio-economic processes related to their class and culture. So, we say that gender is made or 'constructed' by society. Construction of gender differs from one historical period to another and from place to place, according to the dominant group in each culture.

Therefore, we must understand the difference between the sex of one's physical body and the additions and transformations that make up a person's gender. For example, the special *biological* feature of the female is that she can conceive and give birth to children. But the rearing of a child is a *social* process, and the idea that women are best suited for this role is a 'gender construct'.

It is often assumed that rearing of children is as natural to women as giving birth. All the drudgery of child-care gets hidden beneath a whole range of so-called womanly feelings. This *role of mother* reaches out to all. Women are expected to be caring, loving, nurturing and sacrificing, even at the cost of their own health. Being this eternal mother is supposed to be as effortless for women as eating, sleeping and breathing!

The glorification of motherhood is so consistent and widespread, that we fail to see its hidden violence. The ideology of motherhood is emphasised only within the terms and conditions set by patriarchy. Therefore, a woman who bears a child outside marriage is not considered a 'mother'.

These assumptions about woman's nature do not just stay within the family. They extend to women's work-places, also. Housework receives no value, and women's real contribution outside of home gets invisibilised, too. Although women can and do get as actively involved in production as men, they are not looked upon as producers. The man is always considered as the breadwinner of the family, the head of the household.

When we understand something to be natural or biological, it becomes inescapable. But if we understand that gender is constructed by society, we can struggle to change it. We may not be oppressed by bearing children or by having menstrual periods, but we know we are oppressed by the way society understands and treats childbearing and menstruation.

Exploring Gender Stereo-Types

We did an exercise to explore gender-determined qualities of males and females. On a large chart-paper, we made two columns for the qualities that we felt belong to men and to women. Our list looked like this:

Men's	*Women's*
adventurous	patient
brave	tolerant
strong	forgiving
virile	chaste
hard, tough	*motherly*
aggressive	obedient
intelligent	beautiful
rational	soft
decides quickly	loving
manly,	sacrificing
a bread-winner	caring
sexually active	cheerful
handsome	quiet
independent	sympathetic
hard-working	cries easily.....

After looking at our list, we decided which of these qualities we think women and men are born with. We went on cancelling those qualities which our group felt had been learned while growing up. The last one to go was *motherly* ! There was not a single quality left at the end.

The participants were left in a state of surprise, and there was a feeling of emptiness.

What is left? What is a woman?

They felt foolish, as all this time they had upheld illusions about these qualities. They had felt that the different qualities of men and women are natural and basic to each. Looking closely at each, we realised that none of us are *born* with these qualities. We have learned them as part of our growing up, in our relations with others. They are all human qualities, so *both* men and women should be able to acquire them.

Gender dictates and sanctions behaviour. A man is allowed to be aggressive, violent and sexually active, while a woman is supposed to be submissive and passive. She can cross these limits only at the cost of being labelled as 'deviant'.

Women internalise the oppressive values, and unknowingly pass them on to their children.

Gender Relations

The relations between men and women are *gender relations*. That means they, too, are 'socially constructed'. These relations are not without conflict, because they assume the power, authority and domination of men over women. Like class, caste, and race, gender is never absent. Gender values define who is a *bad* woman or a *good* woman. They prescribe the role for a woman in the family, at the workplace and in the community. It moulds her into being silent, obedient, brainless, hardworking, sacrificing and asexual. As gender relations are also social relations a woman takes on the gender-determined roles of wife, office secretary, school-teacher, nurse, sex worker and woman social worker in different social contexts.

If and when a woman's status shifts to acquire some power in the patriarchal family structure, becoming a mother-in-law, sister-in-law or mother-of-a-son, she tends to dominate and imitate male politics.

This brought us to a discussion of *women oppressing women.* Examples were given of mother-in-law and daughter-in-law relationship and wife versus the 'other' woman. . We clarified that women adopt oppressive behaviour as a strategy to survive in this male dominated society. They internalise patriarchal values which control their bodies, minds and hearts. Women act in a play directed by men. In most situations, when women dominate, they do it to gain the favour or protection of a man.

Very often women's subordination is considered natural and 'normal', and therefore is not questioned even when it takes extreme forms of oppression. Biological differences are put forward as the explanation for our secondary status, for our gendered roles and skewed share in the division of labour, and for the violence used against us to keep our sexuality and fertility, and our minds, under the control of men 'in the larger interests of society'.

Our society is hierarchically structured, so there is always a powerful group which dominates descending levels of subordinate groups. It happens that women are subordinate within all the groups.

The System of Patriarchy

Here, we introduced the topic of *patriarchy*. Literally, patriarchy means 'the rule of the father'. It is the system through which men dominate women, using power to keep women subordinated. Through patriarchy, men control the labour, property, fertility, sexuality, mobility, mind and emotions of women..

Patriarchy is propagated through institutions of family, education, the legal system, media, religion and politics. The women did not take long to understand this.

FAMILY AND PROPERTY: My in-laws wanted me to abort the pregnancy. My father-in-law was concerned about the property. 'You are a widow, now. Why should you bear a child?' he said.

I have only one brother. Ever since I've come back to my mothers' house, he never talks to me. I think my brother fears that I will claim my share to the little land and the house.

MARRIAGE: A man on a train once scolded me, 'Why have you no bindi on your forehead. Your husband is alive, and he is your God. You are dependent on him. You are bonded to him!'

> *Every month when I come for the training, my husband tells me, 'Be careful, in Hyderabad there is big bazaar. Don't go anywhere near it! You are a woman, so take care.'*

EDUCATION: I studied upto the third standard. I wanted to continue, but my father refused to hear of it. Everyone else in the family is educated. I had to do all the housework.

> *LEGAL SYSTEM: 'How can you arrest women after sunset? You've no right to do this! What have the women done? If the men are in the wrong, catch them.' The Sub-Inspector shot back, 'Who is this woman? Where has she learned about the Law?'*

Gender Values Related to Work

We did an exercise to look at the *gender division of labour*. The following aspects were discussed in small groups:

- the kinds of work that women *have* to do,
- the work women are *not* allowed to do,
- the basis upon which women and men are given work, and
- the discriminatory ways in which work is valued.

The larger group discussion opened by looking for the kinds and patterns of work that come to women as women, and as mothers. In general, women do not get any pay for most or all of their daily work. This work is not replaceable, and appears to be something for which wages cannot be asked. It is part and parcel of the lives of woman, as women. But men's work is not the same.

Why this dual attitude? Is this double standard restricted to housework? No. Outside of home, wage-earning jobs are not so different. In general, the nature of the job, the conditions at the workplace, the wages paid, the timings, all favour men over women. Frequently women's health suffers. And after 'work' women, not men, are expected to take care of the house.

Women's lives frequently mean no education, no knowledge about the outer world, no assured shelter. Like Sivalakshmi, Sathyamma, Saroja, Suvarna and Parvathamma, they tolerate cruel discrimination for being deserted or widowed, and they carry on with the lowest, meanest jobs of drudgery and monotony.

Gender Values Supporting Violence

After a break, the group came back for a session on violence against women. By now everyone felt that violence is not limited only to the overt forms, like battering, rape and other physical assault. Several of us had experienced this with aggressive and alcoholic husbands. But in our group, women had suffered more from mental cruelty because of their inability to bear a child. Most of the single women were looked upon with suspicion about their relationships, and their mobility.

Covert forms of violence are institutionalised as norms and accepted by people. An example of this is child marriage, prevalent as a widespread tradition in Andhra Pradesh, especially in Medak District. It was seen as normal by most of our participants. Although they could speak of the problems it created for girls and women, they were not so clear about how it was connected to violence, and how it could be challenged.

Another form of modern invisibilised violence which got discussed at length was sterilisation and contra-ceptive abuse of women in the name of family planning.

We discussed the hidden violence carried on through the media. Women are portrayed in stereotyped roles as mothers, wives, and sisters - always sacrificing, loving, with pride in their faithfulness, loyalty and service to their husbands

and family. We also looked at how women are objectified as sex symbols or attached to some product for sale.

Marriage and Childbearing

Getting married, bearing and raising children, pleasing the men and keeping the home are all part of women's stereo-typed role. To have to bear children like a breed-animal and to be pressured to produce sons are forms of invisibilised violence. In male-dominated society, people see them as *duties of married women*.

At this point, to stimulate the participants to reflect, we narrated a story.

A young husband and wife live together in a city. While working in a factory the husband loses a hand. After that his wife looks after him and nurses him. She gets pregnant but it is a tubal pregnancy. In the process she loses her ability to reproduce. As she can no longer bear a child, her husband decides to marry again to get a wife who can have children.

We waited for responses from the group, but everyone had fallen deep into silence. There was anger glowing from some of the faces. Suvarna and Parvathamma were in tears because we had related a story like their own. Nageshwari and Pushpa asked,

If for some reason the man had lost his ability to father a child, would his wife desert him? Instead wouldn't she hide his handicap from others?

The women said that in their villages in order to hide that a husband is impotent, his wife may be allowed or even forced to sleep with another man to get pregnant and have a child.

Are women only meant to produce children? Can or should all women reproduce? Is the 'right' to reproduce every woman's obligation? And why so much craving after sons?

Directly or indirectly, every woman in the group had experienced such pressures to fulfil the norm of marrying and bearing children, especially male children.

Repression of Women's Sexuality

Restrictions on women's physical movements, suppression of women's conscious sexual pleasure, the *taboo* against widow remarriage - these are results of invisible patriarchal control over women's sexuality. Through the four days' discussion we saw that not only is it not women's right to decide and produce children, but that permission for sexual relations, too, is determined by society's norms, not by women's choice. Even commercial sex workers are bound by a set of norms which is only partly different and emerges from the very same system. While wives are treated like breeders of men's children, sex workers are reduced to objects for satisfying men's sexual pleasure.

Society's View of Single Women

The pressure for women to get married and remain in marriage at any cost is intense. Whether forced to be *single*, or having made the rare choice, any single woman is looked down upon, mistrusted and mistreated even by other women. So, women continue in oppressive marriages and sometimes get killed in them. The social stigma which results from walking out of a marriage and from being single is too much to face, too dangerous. While every woman can be subjected to all kinds of violence, the attitude of our society towards single women is one extra invisible form of violence which they have to face alone.

Searching for Ourselves

Deep-seated fear of the violence in society forces most of us to live within the norms laid down for women. In fact, this fear just about dictates the way we live, guiding or influencing almost every action of ours. In so many ways it restricts us from getting to know the world and binds us within a narrow well of reality without the chances or opportunities that men have. Our experiences constantly reflect this. In fact we imbibe this from society so nicely, we get so shaped by society's image of woman that it is difficult to separate out our underlying selves. We told a story to elaborate this:

> *Once a little girl dreamed of having long hair. She was forced to cut her hair for reasons she could not perceive. She was told that it would be more convenient to take care of short hair. As she grew she came to like her hair short. But she reached a point when she was supposed to be grown up, and people around made her grow her hair long. Because of society's ideal of beauty, her wish was side-lined once again.*

This simple tale shows how such an obvious feature of one's body as one's hair is subject to manipulation by society. When a seemingly trivial thing like hair is controlled by society's norms, what can one expect for other things? So, while knowing about one's body parts and functions is

important, the knowledge is far from complete unless one looks at the *social construction* within which the body has to live.

The extent to which we imbibe the norms expected of us was an aspect that we felt necessary to explore. So, we took up a provocative role-play. We were certain the participants would have varied viewpoints.

> *A husband works to earn in the city. His wife is back in the village. For nearly a year he doesn't write or send any money. But when he falls ill, he calls for his wife to look after him. The wife does not have enough money for the journey. She has to cross a river to reach the city. She pleads with the boatman to ferry her across. After much bargaining, the boatman obliges her, on condition that she sleep with him. As she must reach her husband, she submits to the boatman and manages to reach her husband in the city. She takes care of him dutifully, and he gets well. One day after he gets well, he asks her how she managed to reach him without money. In good faith she tells him, not hiding anything from him. He reacts with anger, beats her, and throws her out.*

The role-play led to a heated discussion. Not only did it force all of us to think, but it drew out what we believed and felt about society's norms for controlling women's sexuality. Three points of view emerged:

- that the body of a woman is sacred, and even for her husband's sake she shouldn't have done it.
- that it was alright, because she had done it for her husband's sake.
- that the husband is worthless - he doesn't deserve what she had done for his sake.

Most of the participants disapproved of what the woman did in the story. It was accepted as normal that one should remain faithful to one's husband. Women's sacredness is somehow connected to being a part of man's property. So, there was a strong tendency to feel that the husband's property rights were violated by that woman.

The discussion gave us all an idea of how difficult it would be to change values that are part of one's world-view. Women are taught to look at their bodies, including their sexuality, as the property of the husband, whether he be future, present or dead.

A woman is always held responsible to uphold the izzat (honour) of her husband, her family and community. She is required to guard it at all costs, including denying herself her wishes, desires, choices over her career, work, body and her very existence. Izzat is one big myth. We experienced how the myth of izzat is used as a tool of sexual oppression for women.

We then gave the participants another exercise, *What does it mean to be a woman?* We explored the ideas of a 'good' woman and a 'bad' woman.

⇒ Good Woman: a *mother*, a loving mother, a dutiful and loyal wife, an obedient daughter, a pure virgin, a woman who stays at home, a woman who bears a son, a shy woman, who covers her head in front of men, a quiet woman, a woman who can cook, a sympathetic woman, a tolerant woman, a woman who suffers, a woman who never says no....

⇒ Bad Woman: a *woman*, a *widow*, a deserted woman, a sexy woman, an assertive woman, a loud woman, a *'prostitute'*, any single woman, a woman with loose hair, a woman without a bindi, a woman who wears gaudy or flashy clothes, a woman in pants, a woman who moves around, who is out at night, a childless woman, a woman who has only girls...

Women's Struggles to Change Things

Now, the question emerged, *What can be done to change it all?* Through all the ages, women have struggled against injustices and have protested through songs, poetry and stories.

We started nearby with the *Telangana struggle* in Andhra Pradesh from 1941 to 1948. Left mass organisations voiced the hopes of thousands of peasants for 'land to the tiller'. Women came out of their homes to struggle equally with men, and played an important role. But once the struggle was over, they were pushed back to their stoves and grindstones, and no change came about in their lives.

In the late seventies and eighties, in cities like Bombay, Delhi, Hyderabad and Madras, women's issues became visible in the public media. Scattered *autonomous women's groups* came up in the urban centres. Each group found its own distinct identity, and although they never aligned with political parties, the groups were political.

A network grew between them, and thought and strategy developed through newsletters and journals and at women's conferences.

With slogans like *'personal is political' and 'take back the night'*, women questioned oppression. They protested against rape, sexual harassment in the workplace, and bride-burning, raising the issue of violence at all levels - in the family, through the media and at the hands of the police and judicial machinery. These struggles have brought about some changes in the law. While the effects were limited, they were seen as a first step in reversing violence.

In the eighties, the women's movement began to highlight how modern technology is used against women, especially in the field of health. Women's groups showed how oppression of women has reached new heights of sophistication. They launched campaigns against *amniocentesis for sex determination* to abort female embryos, against *harmful hormonal contra-ceptives* like Net-en, Depo-Provera and Norplant, and against the new reproductive *technologies* meant to enable women to bear a man's biological child at any cost

In the nineties, despite the wide-spread campaigns, such oppressive *technological trends* in the health field continue. A blatant example of finding easy high-tech fixes to avoid social responsibilities is the recent scandal of hysterectomies conducted on a group of mentally disabled girls and women in Pune.

Another feature of the nineties is the wave of women's struggles against liquor in various parts of our country, particularly the militant *anti-arrack movement* of Andhra Pradesh. The impetus of these movements comes from increasing economic burdens and violence on women in the home. Similar anti-alcohol movements are active in many parts of India. Currently women in Andhra have won a government ban on the sale of arrack, now extended to the sale of all alcohol. It is a temporary victory, but women have felt the power of their organised will.

Another sustained struggle that the women had initiated at the rural level is the Chipko Movement. This struggle is against the massive deforestation of the Tehri Garwal hills in Uttar Pradesh. This affects the lives of women who have to face hardship in search of fuel, fodder, water and forest products. It threatens their very right to livelihood. Raping the forest is like violating their own bodies.

The struggles have brought the women out of their homes and helped them to see the strength of collective action. To some extent it has made them aware of and challenged the myths which so far had been accepted as natural. Understanding the dynamics that are oppressing women at various levels, planning of campaigns which have made issues public have exploded the myth that women are unable to think and act. Women have linked their struggles to broader movements of environment, tribal identity, landless agricultural labourers and trade unions. Through all this women are challenging gender relations.

Women no longer want to end up hopelessly victimised. They are continuing to break open the path for themselves and future generations - a path which values diversity and gives space to all.

I am a Woman

I am a woman, hear me roar,
in numbers too big to ignore;
For I know too much to pretend,
'cause I've heard it all before,
and I've been down there on the floor.
No one's ever going to keep me down
again.

You can bend but never break me,
'cause it only serves to make me
more determined to reach my final goal.
And I come back even stronger,
not a beginner any longer,
'cause you've deepened the conviction
in my soul.

- verses from a song,
origin unknown

Politics of Health and Population

Objectives:

- to define health from a perspective of women's rights
- to see how far government and non-government schemes have focused on women's health needs
- to analyse health within a socio-economic and political framework of class, caste and gender
- to expose the myth of 'population explosion', probe the politics of population policies, and see how the family planning programme under-cuts government health care
- to learn about harmful contra-ceptive methods and to share the experiences of campaigns

Methodology:

Story:	narration of RAKKU'S STORY
Role Play:	modern health care system - perceptions
Charts:	statistics revealing health status demographic statistics contra-ceptive methods, effects
Case studies:	NGOs pressed to fulfil targets; sterilisation (tubectomy) abuses
Viewing:	film, SOMETHING LIKE A WAR slide-show on Bangla Desh Drug Policy
Activity:	composing a song on population politics, *SARKAR ANNA NEEKU SALAAM ALEIKUM'*
Assignments:	survey of available health services; collection of contra-ceptives, from the PHC & over the counter
Demonstration:	FP Methods -condoms, IUD, Norplant, Depo, diaphragm, spermicide, female condom

Women Confronting the Health System

RAKKU'S STORY, **tells us** about a poor dalit woman from a village in Tamil Nadu and her attempt to save the life of her small child. We narrated her story to help understand class and caste biases in the health care system. Journeying with Rakku we studied ill-health, tracing the barriers she confronts. The many questions raised by her child's death led us step-by-step from Rakku's village home to the structures of Indian society as a whole. Then we related this analysis to our personal experiences with the health care system.

Each one could remember similar experiences as Rakku's trying to save a loved one, knowing too well the powerlessness because of poverty. It seems that for the poor in this society there is no such thing as right to live or right to health care. Doctors' attitudes and the fate of poor people triggered emotions from Pushpa and Ramalamma. Pushpa began to cry during the narration. Then, right through the tears, she vented her anger and frustration at the medical system.

My husband had diarrhoea. I was alone at home. I took him to the hospital in a rickshaw. I asked them to give him glucose. Then I had to return home as the children were very young. I was not there with him, and the careless authorities didn't attend to him. I had no money. My husband died because of their negligence. They could have saved him if they had treated him. Alone I have had to raise my three sons!

Ramalamma's spirit had sunk very low. She had gone through an even more similar experience.

For three months, my infant son was very sick. I showed him to several local doctors. My husband was too lazy or too scared to accompany me to the city hospital. I took my child alone. Before I could reach the hospital with my son, he died. I still made my way to the hospital hoping he was alive, until the doctor declared him dead. I picked up my child, wrapped him in my sari pallu and sat there for hours....

Slowly I gathered my courage and took him home. I was frightened that someone in the bus might notice I was carrying a dead child. I clung to his body not to create suspicion in people's minds. Once I reached my village, I gave a loud cry and yelled out my feelings. Then, I fainted. Relatives took over the funeral rites and I didn't know anything for three days. Since then, even though it was long ago, I feel tight in my stomach when I remember this.

Even now I ask myself, why are there no proper health care facilities in my village? Why doesn't the government ANM visit? Why is there no decent treatment for children? Why are there no buses from my village to the town? Why can't the hospital come to my village instead of being in the town? Why can't the doctor come and help us where we are? Who will answer for the death of my son?

The major cause of ill health in our country is unequal distribution of resources and exploitation of the labour of the poor. The illnesses of the poor are usually simple and preventable, but still they suffer and die because they lack basic things like food, clothing, shelter, health care and education.

Access of Women to Health Care Services

Poor and rural women hardly have access to health services, government or non-government.

To prepare the group for the topic of 'health politics', we had given an assignment in the last month's session. The participants were to collect information about the availability of health services and make a table showing the distance, the personnel, the type of service. We would see how much the services address women's health needs. The table which resulted is the following:

Villages	Facilities	Distance	Personnel	Services
21 villages in 4 districts:	Sub-Centres	2 - 8 kms	ANM, one visit per 1-3 months	Immunisations, Vitamin A, Iron & Folic Tablets Deliveries, Condoms
(Nellore,	PHCs	6 - 13 kms	1 doctor, 1 ANM, 1 compounder	Copper-T, OCs Family Planning Operations; MCH Programme
Vishaka-patnam,	District Hospital	10 - 40 kms	doctors, nurses, technicians, etc.	Same as above, and MTP (legal abortion), Diagnostic Tests & Surgery
Anantapur, & Medak)	Travelling quack doctors	village-level	RMPs constantly available	Both RMPs and Doctors give injections - pitocin, glucose & medicines like antibiotics, steroids & abortifacients
	Qualified Pvt Practitioners	In nearby towns	doctors in clinic or dispensary	
	Local Healers	same or next village	traditional dais herbal healers	Assisting at home births Herbal medicines

The participants commented:

- *The Government PHCs work from 10 in the morning to 4 in the afternoon. That's when we are out at work, so it means losing a day's wages.*
- *The health centres are too far away. Public transportation is bad, or just not there at all.*
- *Private doctors fleece the poor! Just to see the doctor once, we have to spend fifty to a hundred rupees. We can't afford the tests and treatment.*
- *They never tell what medicines they give us, or what really is wrong. If we dare ask, they shout at us.*
- *Doctors treat us like we're dumb. Some stare at us, and they touch us when there's no need. Some grumble and humiliate us. Women doctors insult people just as much, sometimes worse!*
- *Medicines for TB, Leprosy, Malaria & other problems are not available at the PHC.*
- *Before childbirth, often the RMP or the ANM gives an injection to make the pains stronger. This can make the vulva tear, or even the womb can rupture. If that happens, the woman dies.*
- *If we go for abortion to the government hospital, they make us agree for Copper-T or operation. Even then, the doctor asks us to come to her private clinic and we have to pay.*
- *They do tubectomy operations without blocking the pain. They ask us to buy the injections, but they don't give them. After tubectomy, they never care about women.*
- *At the PHC, they don't pay attention if we say we have white discharge or too much bleeding.*

Women rarely approach any kind of health service. If they had gone at all, it is usually for their children or menfolk. They end up at these places for themselves only when they get so sick that it stops them from working. Compared to men, three times fewer women visit hospitals and health centres. They have to work all the time. Going to the hospital means losing a day's wage. *Women and the poor have no right to fall ill!*

Besides not getting nutritious food, women are doubly burdened with household and outside labour. Because of the depletion of natural resources, including deforestation with its widespread effect on the ecology, women have to walk much more every day in search of fuel, fodder and water. Carrying the responsibility of keeping the family together, women are under great emotional and mental stress. This sometimes results in breakdown. Most of women's work is arduous, repetitive and thankless, and is performed in poor conditions which pre-dispose women to health and occupational hazards.

So, the things that trouble women most are tiredness and weakness, backache, joint pains and fevers. In the beginning, our participants surprised us with their lack of concern as such for anaemia, night blindness, tuberculosis, malaria or even post-tubectomy complications. It appears that they view these as conditions which they can live with!

In the areas where our participants live and work, most deliveries (96%) are conducted at home by untrained traditional *dais*. After three to four children, most women opt for tubectomy done in camps without safety and with no post-operative follow-up care.

Then, for common problems like burning while passing urine, heavy white discharge and too much bleeding, women would rather suffer in silence than approach a nurse or doctor and risk being questioned about their character and their sex lives. If they are childless, they are pushed to see doctors. If any tests are done for infertility, no decent explanation is ever given.

On the other hand, men approach doctors freely for minor ailments or chronic and recurrent problems. Some participants had come to know that men often go to take shots of penicillin for sexually transmitted infections (STIs).

The national health services have only promoted contra-ceptives and sterilisation operations, and have half-heartedly conducted the mother-and-child health (MCH) programme - giving little more than anti-tetanus vaccine and iron tablets. They see men as producers but women only as reproducers. The medical profession and health planners fail to think of what happens to women who are not reproducing. And marginalised women - teen-aged, single women, older women and commercial sex workers - can't get care even when they do have children.

Health of Women Today

The government expresses concern for high 'maternal mortality'. But, deaths related to reproduction make up only a fraction of the total deaths in women. All the same, 'maternal mortality' statistics are used to force untested contraceptive measures on women, which 'experts' say are less hazardous than pregnancy and childbirth.

Ill-health (as 'morbidity') is estimated to be about sixteen times greater than female deaths. Countless women and girl children suffer from nutritional deficiencies and anaemia, making them prone to infections like tuberculosis, malaria, diarrhoea, and pneumonia. They withstand constant stress and injuries from abuse and violence, from double burden of work and from social restrictions.

Sexual and reproductive problems are a vast *area of silence*. Uncounted millions of women suffer from vaginal and pelvic infections, womb descent ('prolapse'), cancers and childlessness. Although, since the mid-seventies, abortion (as 'medical termination of pregnancy' or MTP) has been legal, most women do not have access to safe facilities.

All this disorder in women's health results from a great *global illness* -

> *increasing subordination of women within the unsustainable economic and political growth of capitalism.*

The Government is bent on population control, even while cutting back on public health expenditure. Every five year plan the budget for health services gets slashed while more money is set aside for the family planning programme. So, there is little hope that the health prospects of women will improve. The declining sex ratio favouring males speaks of the precarious life situation of women and girl children in most of India. Under the New Economic Policy (NEP) of the nineties, privatisation of health care and curtailment of essential social supports threatens the health of women even more.

A Look at Some Statistics

Statistics give us a different kind of an over-all view of women's health. We took a close look at the figures for sex-ratio, age-wise deaths of males and females, and the causes of death in women.

Female-to-Male Sex-Ratio: This is the number of females to one thousand males in a population. In India, there are now 929 females for every 1000 males.

Under *ordinary* circumstances in a population, at any given point of time, there are likely to be more females than males. Females tend to outnumber males because the male is weaker. More males than females die in the womb, and around childbirth (aside from female foeticide and infanticide). Only after birth do girls meet up with social neglect and violence, and then they die more often than boys.

In most parts of India, the sex ratio is low because of *extra-ordinary discrimination against females*. The statistics for India and some of the states are below (*Census*, Govt. of India, 1991):

Year	India	A.P.	Kerala	Raj.	Bihar
1901	972	986	1004	905	1054
1941	945	980	1027	906	996
1981	934	975	1032	919	946
1991	929	975	1040	913	912

It was interesting to see various trends which reflect from these figures. The sex ratio has been gradually decreasing in most places, but it is higher in the southern states of Andhra and Kerala compared to the northern states.

Age-wise Male and Female Deaths: Compare the deaths of females (per 1000 population; *SRS*, GOI, 1989) to males in different age groups.

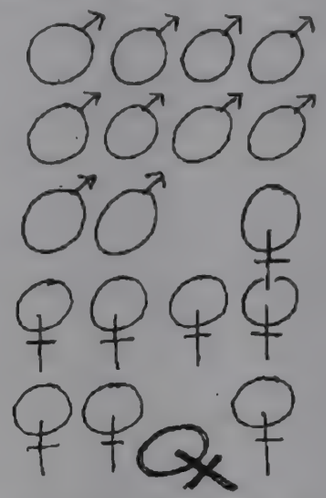
DEATHS per 1000	Male	Female
0 - 4 yrs	31.8	34.9
5 - 9 yrs	3.0	3.4
10 - 14 yrs	1.4	1.7
15 - 19 yrs	1.8	2.2
20 - 29 yrs	2.6	3.0
30 - 39 yrs	5.4	3.9
40 - 44 yrs	9.0	6.4
45 - 49 yrs	14.0	10.3
50 - 55+ yrs	20.7	16.0

The participants thought of explanations for the figures at different ages.

⇒ *in child-hood:* infanticide, starvation, mistreatment, neglect, violence; abuse linked with child marriage.

⇒ *in the middle years:* neglect, torture, burning, suicide; unsafe abortion, complications of pregnancy and child-bearing, harmful contra-ceptive methods; tuberculosis, malaria, cancers.

⇒ *in the later years:* less abuse because of change in status with age.



Causes of Death in Women: Here we compare the important causes of death in women (*Health Statistics*, GOI, 1983). Most deaths in women are *not* due to reproductive causes.

Age Range -->	15 - 24	25 - 44	45 - 64
Infections, Parasites	23.1%	27.7%	17.2%
Accidents, Violence	23.8%	14.0%	-----
Pregnancy, Childbirth	13.2%	9.4%	-----
Heart Attacks, Strokes	---	11.8	29.7%
Cancers	----	-----	11.1%
Other Causes	12.0%	10.5%	12.7%

Deaths related to causes other than pregnancy, such as parasitic and infectious conditions, accidents and violence, are high. They are a reflection of poverty and patriarchy. Government health services do not address these realities, and even MCH services are miserably watered down.

Hierarchy in the Medical System

We then began to probe deep into the dominant health system to unearth gender biases and patriarchal controls. Hierarchy is one of the characteristics of the present dominant health system.

> *There are many hierarchical bases for discrimination in health and medicine, among them class, caste, and gender.*

The western medical system is dominant over the indigenous systems. It is a legacy of the British colonial history of our country. Within the indigenous systems, the classical (upper caste) indigenous medical systems dominate over the local streams of folk health traditions. Even in these local traditions, men healers tend to consider themselves superior to women healers.

Class and caste hierarchy is obvious in the social division of labour in the medical system. Manual work is done by the lower class and castes, while the upper class and castes are in control of the mental work, including the finer skills and levels of decision-making. Hence, the policies and the services are designed to suit the needs of the socially powerful.

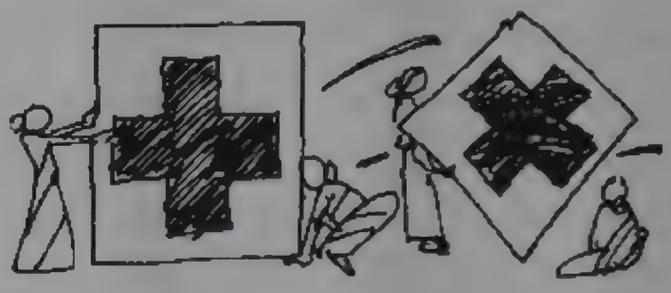
Gender division of labour operates in the health system, too. Doctors are usually men belonging to the upper class and to an upper caste. Nurses are all women (with rare exception) who come from lower or middle class and caste.

Women take part in the health care system as health care providers - nurses, doctors, ANMs, dais, community health workers and indigenous healers - and as patients. The doctor-patient relationship is another form of hierarchy and a version of personal politics. Just as the patriarchal family serves to replicate the values of society at large, there is a *family model within the dominant health system*, represented by the doctor (boss/father), nurse (servant/wife/mother) and patient (child).

Personal politics within the health system, between doctors and nurses or doctors and patients, may take the form of males indulging in *sexual abuse*, just as happens in the family or at the workplace. Our group came out with this as a surprise when we gave them a role-play exercise to explore their experiences of the health services.

> ⇒ We divided the participants into three groups of project staff and sangha members mixed together. Notably, each group highlighted their experience of sexual abuse and violence at the hands of health personnel.
>
> *One group depicted molestation of a woman on an examination table by a doctor. They acted out those unwanted and needless touches that are usually subtle and confusing at first, but so well known to women. The second group acted out a rape by a doctor under the pretext of doing a private medical examination. The third group showed the rape and death of a woman after over-drugging her.*

All three episodes of the role-play were real life experiences. Later, we realised that the project staff had dominated in each group. They took the main roles of doctor, nurse and technician while giving the roles of patient, hospital attendant and relatives to the sangha women. So, the common theme of sexual abuse in all three role-plays reflected the project staff women's perceptions.



Gender Bias in Medical Technology

Bias against women permeates the field of medical technology. Technology serves and maintains the values and norms of society. *Sex determination* using amniocentesis or ultrasonography to abort female embryos is a glaring example. It legitimises son-preference in Indian society.

Technology is often seen as a modern solution for social problems. Hence, we see our family planning programme based entirely on contra-ceptive technology. And the easy solution to the problems of menstrual cleanliness and unwanted pregnancy in mentally-retarded women is high-tech hysterectomy (removal of their wombs)! In a patriarchal society like ours, technology tends to be coercive and manipulative. It easily becomes anti-woman and anti-poor. Technology is the instrument of the population control policy.

The Medicalisation of Health

Today health care is becoming an industry. Health no longer seems natural, but needs to be *bought*. To make profits, the 'health industry' medicalises all natural processes, including menstruation, pregnancy, and menopause. Even fertility is treated like a disease that needs to be eradicated with 'anti-fertility vaccine'. Medical care givers, multinational drug companies (MNCs), medical scientists, technocrats and the state are all involved in this.

Privatising the health services, the government abandons its responsibility to protect the health of the people, letting the cost of health care shoot up beyond the reach of the poor. While the 250 essential life-saving drugs are in short supply or unavailable, about 75,000 irrational, useless and hazardous medicines flood the market, sold under countless trade names. The drug industry makes money while keeping people unhealthy and poor.

We looked at a slide-show called BANGLADESH DRUG POLICY. It showed how a small country like Bangladesh could fight the foreign multi-national drug companies, banning harmful and irrational drugs and ensuring the supply of essential drugs.

The population control policies prepare fertile ground for the MNCs to produce and develop sophisticated new contra-ceptive technologies. Among these are the hormonal injectibles, surgical implants, microfine nasal sprays, spermicidal electro-gels, anti-fertility vaccines and so on. We can also expect new frontiers of sex-determination and sex-selection.

Modern Medicine

Modern medicine or 'allopathy' has a *mechanistic* and *reductionist* view of the body. Making much of it being *'scientific'*, the medical profession *mystifies* it with medical language so that ordinary people cannot understand. It depends on a *hierarchy* of knowledge and persons - modern knowledge superior to traditional, doctor with power over patient, and rich and paying patients preferred to poor and 'non-paying'. It services *sexist* biases in society, giving preference to male needs. It ignores underlying causes, like poverty, violence, and environmental destruction. At times, it may often be out-right *irrational*. Nowadays, alternative and holistic approaches to health often refer to allopathy as 'orthodox medicine' rather than 'modern medicine'.

Modern medicine recognises 'diseases' distinct from persons and their lives. It tries to interrupt the course of diseases with drugs. While it *fights germs* , it side-lines our body's capacity to keep or regain balance if cared for and nourished properly. In particular, towards women's health its approach is to use treatments which suppress symptoms without finding or healing the real causes. For example, using synthetic hormones for post-poning or 'regularising' menstruation, for contraception, for suppressing breast-milk, and for 'replacing' estrogen at menopause is common and unchecked, especially in the towns and cities. Such treatments are harmful. On a large scale, when women are anaemic and under-weight, they can be disastrous.

We are not denying modern medicine a place. We recommend allopathic tests and treatments in certain conditions. Still, we try to place these in the context of a women-centred holistic approach to healing.

Indigenous Systems of Medicine

The formal indigenous systems of medicine (ISMs) have become subjugated to allopathy because of colonial history and the in-roads of capitalist development. They are holistic systems in contrast to allopathy, yet they are loaded with *patriarchal biases* and are *hierarchical*. They treat women and the poor in a biased and patronising manner. For example, in dealing with a woman who has 'white discharge', the prevalence and dynamics of sexually transmitted infections is ignored. Practice of ISM is not covered by the same legal rules and regulations which apply to doctors. Also, most *vaidyas* and *hakims* use dangerous allopathic drugs without knowledge or care for the harm they cause.

Although it did not originate in India, homeopathy has taken root in our country because of its holistic view of health and because of the side-effects of allopathic medicines.

The ISMs are *not the same as the local health traditions* (LHTs) of ordinary people, although they have historically and culturally developed from local healing practices. The ISMs consider the LHTs to be inferior.

Local Health Traditions, Women Healers and Dais

In every rural area among the common people, women healers and dais still carry age-old knowledge of herbs and healing skills. In fact, in communities and families since ancient times, women have traditionally been the main providers of health-care. As modern medicine develops as an industry, women are systematically stripped of this healing tradition. They have all but lost their role as healers. Doctors ridicule and negate women's traditional healing resources and capacities, preferring to see them as 'patients'. Their experience is devalued and discounted. As the forests are cut down, their herbs for healing are destroyed and 'development' replaces them with un-natural synthetic drugs.

Our older participants remembered *women healers* from their childhood and described them. Many were *dalit* women with 'guts' who questioned the dictates of their men and of the higher castes. At critical moments, in the absence of outside supports, they handled all sorts of problems with confidence and skill. Only a handful of them live today.

What is Health, and What is Women's Health?

When so many things are wrong with health, we wondered, *What is health?*

We thought,

health is not snatching someone else's share
...is not having my body tampered with
health needs struggle
health is peace of mind
health is having a full stomach
... going off to sleep without a bashing

health is to break into a smile
... feeling you are a whole person
laughing and dancing
...being satisfied with what you need

health is treating everyone equally,
and when a man shares the house-work.

health is not being ridiculed or belittled
health is being appreciated,
feeling one's body glow...

Right to health must be seen within a framework of comprehensive women's development. To be and keep healthy, women must have their basic needs fulfilled. They need equal status in society, equitable division of labour (including production, child-rearing and house-work), assured and fair wages or income, safe working and living conditions, adequate and clean food and water, education and health care, and freedom from violence.

The Politics of 'Population'

Population policies intrude so much upon women's health and are such a threat today, that we are forced to focus upon this topic. Actually, we had this session after Fertility Awareness, but here we consider it along with the Politics of Health.

To assess the extent of the participants' present understanding about population and family planning, we threw open a few common statements:

India is poor because of over population.

Poor people have too many children. They need too much food, and they burn too much fuel and cut down all the forests, causing pollution of the environment and depletion of resources.

The poor have too many children because they are illiterate.

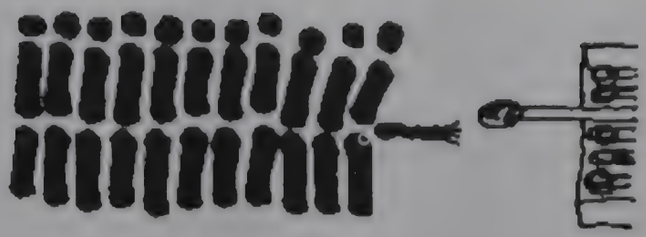
Hum do, humare do, magar ve panch aur unke pachees! (Hindi: We two, and ours two; they are five and they have twenty-five.)

They reflected on these statements. Most said they felt over-population is *the* cause of poverty. Some were hesitant, but they didn't know how to explain why they did not agree. To most, the growing number of people was obvious - the land was being divided and people were migrating to the cities. There was shortage of food. The public media, school textbooks, movies and conversations they had heard had influenced them, too. Some said that a large family depletes the land and food, so it makes poverty worse, but it is not the main cause for poverty.

They could not go on to question why many have little, while a few have plenty; how poor people work hard to produce wealth which they have no share in; why those who have just two children are still poor; or, why poor people want to have more children, and how much does a poor family really consume. Yet, the experience of the group was that poor women everywhere want birth control methods. They even bear known risks to get themselves tubectomised without their menfolk's' knowledge.

We decided to begin taking a hard look at the ***myth of over-population*** -

that the world's problems arise because poor people are too many, and they multiply at an alarming and uncontrolled rate, using up the resources and unbalancing the environment.



The Myth of Population Explosion

The *theory of population* was proposed in England by Thomas Malthus about two hundred years ago. It states that the cause of poverty is the tendency of the poor themselves to multiply and to devour surplus wealth. In other words, the poor stay poor because they mindlessly have more children than they can afford.

Since the seventies, evidence of destruction of the environment has arisen. The rich countries are very worried about it. Without admitting that they bear the largest measure of guilt for pollution and depletion of resources, they have set up an alarm about the so-called 'population bomb'. Malthus's theory of population was taken out of the cupboard to support this perception of not only the problem of world poverty but of environmental destruction as well.

Governments use this old theory in new garb for justifying controlling the growing numbers of poor people. The state's focus on controlling the fertility of the poor is influenced by economic forces in the countries of the North. The 'developed' northern nations blame the 'developing' southern countries, charging that their ever-growing populations are the cause for destruction of the planet without ever questioning their own over-consumption and degradation of the earth's resources.

Blaming population for causing poverty is an easy way out for the government to explain all it's shortcomings and shift the blame to so-called reckless behaviour of the poor. This point of view does not question the system which breeds exploitation, unemployment, unequal distribution of resources, over-consumption by a few, and destructive modern development. Also, in nailing blame on the poor, the state hopes to avert masses of impoverished people from rising up.

Poverty and 'Family Planning

We asked the participants, *Why do the poor want more children?* They said,

The children of the poor die often. The government does nothing to ensure that they live.

Besides, the poor need their children, especially sons, as security in ill health and old age.

Even from the age of five, children do work at home. At ten, they are earning.

It was an eye-opener for the participants to know that in developed countries, women are supposed to produce more children. While pressurising the women, those governments highlight the role of 'motherhood'. Women are made to feel incomplete unless they produce families, and guilty if they decide to pursue a career instead. But, this is only for the well-off white population, seen as 'intelligent' and 'able'. There is no such place for coloured and indigenous peoples and other minorities, including the disabled. Either way, the state tries to control the fertility of women, even at the cost of their health. So, the purpose of population control is not to remove poverty, but to remove the poor, the handicapped and the unwanted.

M. Sumati interacted with the group, and composed the song, *'Sarkar Anna Neeku Salaam Aleikum'* - it includes all that we had discussed on population politics.

Sarkar Anna Neeku Salaam Aleikum

(chorus)
Oh, government brothers, we salute you!
This 'small family norm' is a mystery to us.

You say, poverty won't go
if we keep having children.
Your employees roam village by-lanes,
telling us to stop at two.
They drag us to camps
where butchers dressed in white,
Throw us blind-folded on a table,
and go chop chop chop,
Then fling some medicines at us
and chase us out.
Our strength goes skitter-scatter,
Our last breath seems
to fall from our eyes.
For our shock and pain
nobody cares -
we're like stray animals.

Will poverty really go
if we stop having kids?
We've neither shelter,
nor cloth to cover our bodies.
There's not hope
of wages for six seasons.
For aches and pains and sickness,
there's no hospital for us.
There's nothing to feed
the child on hip or in the belly.
There's nothing for the old woman
who slaved all her life.
We've neither land nor animals
nor children to help in the fields,
No food to eat, no water to drink -
Brothers,
Only poor people will disappear,
poverty won't go away...

In family planning's name,
our lives are made a misery
With Mala-D and Depo,
Copper-T and laparoscopy.
New technologies
make our bodies into laboratories,
Day by day, we become prey to sicknesses.
You keep the men in comfort,
yet pressurise us women,
Already marginalised and
used by the health-care system.

Look at the greed of the West, Brother.
Cut our tubes, let our blood flow.
Control population -
Only then will trade pacts be signed.
They tell a lie
that the world is too crowded.
In their own countries,
they pay families -
Five hundred dollars for a child,
a thousand for the second!
Is it for the white race to grow,
that dark races must decrease?
You say, poverty won't go
if we keep having children.
This way you smooth-talk us,
keep us under control.

Coercion in Family Planning

If a women goes to a PHC for abortion or delivery, she has no choice but to have an IUD inserted or to get a tubectomy.

The state has only one aim - to reduce the population! It uses all kinds of manipulative and coercive methods. With incentives like *saris* and money it bribes the people to comply. If they don't, it uses dis-incentives, like holding back ration cards, medical and maternity benefits, salaries and promotions.

For the first time, the state of Andhra Pradesh has exceeded its target - performing six lakhs sterilisations - during 1993-94 (*Hindu*, 3/5/'94). We need to stop and listen to stories behind these figures.

⇒ *In Lingareddipalli village of Ozili Mandal, Gudur Revenue Division, people were obstructed by officials from harvesting their crops, unless they underwent a family planning operation. Flags were placed on fields belonging to persons refusing to comply. With the local NGO's support, the people went ahead and harvested. The NGO's activities were reported to the Collector as anti-government.*

⇒ *In the same area, nine hundred families of forty villages were denied access to PDS food-grains, house-site pattas, and government loans because they refused laparoscopic sterilisation.*

The media constantly bombards people with family planning propaganda. Health-workers, ANMs, teachers and other government employees are under pressure to fulfil targets, which are linked to salaries, increments, promotions and job transfers. It has been proposed in parliament that maternity leave will not be granted to a woman after her second child, and no person with more than two children will be allowed to stand as a candidate for election.

The government says it wants to ensure that women have *choice* to bear children if and when they want, or to select a particular contra-ceptive through a 'cafeteria' approach. To what extent do women *really* have choices? And, without adequate information and health services to support a method of choice, what does she have to choose between?

We saw the video-film SOMETHING LIKE A WAR by Deepa Dhanraj. It documents the excesses of the Government's Family Planning Programme. The following were the participants' observations.

Women in tubectomy camps are treated like animals, caught and their tubes tied under filthy conditions.

They have no names, no faces, no identity, only numbers.

The aim is to do as many operations as possible, no thought being given to how unsafely they are done or the complications.

Before the operation, 'cases' are treated kindly, but afterwards women are given hardly any care.

Very often there is no anaesthesia.

Six of us had got tubectomy done and we could identify closely with the film, as our experience was similar.

The Situation under the New Economic Policy

Through 'structural adjustment programmes' (SAPs), the government is under extreme pressure from outside to control population. Our government's New Economic Policy and its SAP is eroding the public health services. Whatever health supports for women and the poor existed before are now being undermined and dismantled with privatisation. All foreign aid and development loans come on condition that they meet family planning targets. Government health services are made the vehicle for population control, peddling hazardous long-acting, provider-dependent contra-ceptive methods. In Uttar Pradesh, the state government has accepted eight hundred crores rupees for setting up a massive family planning infra-structure in the garb of health services.

Involvement of NGOs: Most non-government organisations doing health work have included family planning programmes along with their MCH services - this is nothing new. But today, NGOs are being roped into fulfilling the government's policy in a different way. They receive large funds through the government channel to carry out family planning work. In Andhra, most NGOs are lined up to accept this.

• *When SVDS Anakapalle was offered the scheme for a six-bedded unit, the project director declined. He had been influenced by one of our participants, and he was one of the few*

who clearly rejected the scheme. NGOs in Andhra are also asked to contribute incentives in cash or kind to the women of their area. Targets are set even for NGOs, and if not met, the local government makes it difficult for them to function.

As a health worker in an NGO, Nageshwari shared her experience.

At the end of March, all the government staff are busy. I had a good relationship with the sub-centre ANM. She visited this month and asked me to motivate women for family planning. I replied,

I'll help you in any other way, but please don't ask me do this.

She was angry.

Why are you talking to me like this?

I said,

You and me, we've been friends. I've helped you all these years. But now, I've learned how these contra-ceptives harm women's bodies, and about PID and other problems they get.

Akka, operations aren't done properly at camps. I'm having a tough time healing infections after operation.

After this, the ANM reported to the Medical Officer that the women staff of the project are not co-operating with the Family Planning Programme. Nageshwari kept on resisting in whatever way she could.

When I visited the PHC for bleaching powder to sprinkle into stagnant collections of water, the doctor scolded me.

Stop worrying about the environment. You should focus on Family Planning! Diarrhoea is because of
liquor and kaleji (fried liver) sold on the roads, not by unhygienic surroundings.

Another project staff participant related her bitter experience about motivating women for operation. *The district Collector asked our organisation to fulfil the targets for Family Planning. Our director requested me to motivate women. I work with tribal women.*

I told the director,

Now that I know of the risks, I can't motivate the women. What face do I have to talk to them when I've made them aware of the risks they face because of the family planning programme?'

He said,

You'll have to do as I tell you. You're an employee here, and it will bring a good name to the organisation..

I was pushed into a difficult spot and had to motivate eight women. I thought, at least if I accompany them, I'll be allowed to enter the operation room, and they'll be careful to do the operation properly. The film we saw - SOMETHING LIKE A WAR - was fresh in my mind.

I took the women to the PHC, saying I would stay with them. But, the doctors wouldn't allow me inside. I felt I had cheated the women.

Marketing Contra-ceptives: In preparation for our session on contra-ceptive methods, we had asked the participants to visit their local PHCs and collect samples and information about the contra-ceptives for women and men. Also, we asked them to go to chemist shops in the local small towns and find out what contra-ceptives and abortifacients are sold over the counter.

This is what they found:

at the PHCs:	Mala-D pills, copper-T, condoms tubectomy, vasectomy
at chemists:	various oral contra-ceptive pills Depo-provera injections high dose estrogen-progestrone ergot drugs as abortifacients high quality condoms

We need to have a better understanding of the role of drug companies and market forces in relation to our need for contra-ceptives. They claim they are 'catering' to women's demands, but in fact, they are seeing to their own interests. Diverting high dose contra-ceptive pills to countries in the South when they are no longer used by women in the North is one example.

Women's contra-ceptive options are determined by the market. Female sterilisations have narrowed the market for hormonal contra-ceptives. Hence, drug companies are all out to push implants and injectibles, under the pretext of giving wider choice to women. They are establishing contra-ceptive markets in the poor countries of the South, where awareness of the hazards is low. All this time, conventional contra-ceptives were distributed through the government health services. Under the new 'social marketing system', contraceptive availability within the public health services is sure to shrink.

Women's Need for Safe Birth Control

All through the ages, women have held the responsibility for giving birth and taking care of children. They have seldom enjoyed sex even within marriage for fear of conceiving yet another child. There has been little scope for negotiation with their partners over either regulation of fertility or child-rearing. Already weakened from overwork and less food, their health has suffered more from repeated childbirths, abortions and infections.

Even so, throughout history people have tried various ways to prevent conception and birth. Staying at one's mother's place, regulating diet, using herbal and other remedies for preventing or aborting pregnancy, observing ritual abstinence from sex during certain seasons or festivals, prolonged breast-feeding, withdrawal of the penis before ejaculation, and avoiding sexual intercourse during parts of the menstrual cycle - these are all ways people have found to regulate fertility to some extent. With these close-to-home methods, fertility was within the control of people. Today, the state has taken over this control using technology and plays all kinds of tricks on people and on women's bodies.

Actually, women need birth control measures only for certain days when they are fertile during every month. It is estimated that women are fertile for only about four percent of their life-time! In contrast, *a man is fertile all the time for most of his life*, but we never hear people talk about men's fertility. Even though there are easier and safer birth control methods for men, like condoms and vasectomy, men rarely take responsibility for their own fertility. A woman needs safe contraception for the days she is fertile. Since a woman is naturally infertile most of the time, she does not need the long-acting invasive methods.

We looked at samples and pictures of all the various contra-ceptive methods. We learned how each one is used, how it works, and what problems can arise by using it. We told them the history of each method, and considered its acceptance within culture.

Further, we examined the features of each method which the Government finds convenient or inconvenient for implementing the population control policy.

Invasive, Provider-Controlled Contra-ceptive Methods

Besides traditional methods, fertility awareness method and the barrier methods, all the others are invasive. They effect our whole body, and have varying degrees of side-effects, ranging from menstrual chaos to chemical and hormonal imbalances. Not only do they destroy or distort a person's fertility and immunity, but they may also affect the health and fertility of generations to come.

- ***anti-fertility vaccines:*** Still under research, vaccine injections are likely to be launched into the population control programme. We warn women against taking this vaccine, as it interferes with our body's immune system. Turning our body against itself to fight pregnancy, they treat fertility as a disease! No one knows what the long-term effects and disorders will be.

- ***long-acting hormonal contra-ceptives:***

Implants: Norplant consists of six match-stick size rods containing a form of progestrone. A cut is made and the rods are placed under the skin of one's upper arm. There they slowly release the hormone into the blood-stream. Norplant is supposed to work for five years.

Injectibles: Net-En and Depo-Provera are both forms of progestrone injected into the muscle tissue every three and two months respectively.

We advise women not to go in for these. They are put into one's body and stay for a long time, and so their effects are irreversible. They are controlled by the providers, not by the women. Besides suppressing ovulation and changing the womb lining and cervical mucus, they chemically distort the way our body functions. Not much is known yet about their long-term side-effects.

- ***hormonal contra-ceptive pills:*** We don't advise a woman to take oral contra-ceptive pills, either, because of the hazardous effects on the whole body. But, we recognise that hormonal pills are in a woman's control, and at least she can stop them if and when she wants.

- ***intra-uterine contra-ceptive devices:*** An IUCD - like the Loop and Copper-T - is inserted into one's womb. In trying to expel the IUCD as a 'foreign body', the womb prevents the fertilised egg from implanting. It opens the womb environment to the risk of infection, both during insertion and because of the threads coming down through the mouth of the womb. Among the many side effects and hazards which women ex-

perience are heavy bleeding and pain, infections, allergies and tubal pregnancies.

- ***male and female sterilisation:*** Tubectomy and Vasectomy are invasive surgical procedures which are permanent. They prevent sperms from meeting the egg by blocking either sperm-tubes or egg-tubes.

Tubectomy is preferred by most women in a no-choice situation. Once a woman has the number of children she wants, she often turns to tubectomy. This doesn't mean it is an ideal method, especially for women who are anaemic and malnourished. In fact, women experience a lot of side-effects. What they complain of may be the tip of an ice-berg.

Tubectomy is a more difficult and invasive operation because the egg-tubes lie deep inside the belly. It is done by one of two methods.

⇒ A tiny cut is made just below the woman's belly button through which air is introduced. Through this cut, a laparoscope is inserted so that the egg-tubes can be seen. Each of her egg-tubes is caught and clipped.

⇒ A 2 to 3 inch cut is made in the pelvic area. The egg-tubes are pulled up and tied or cut.

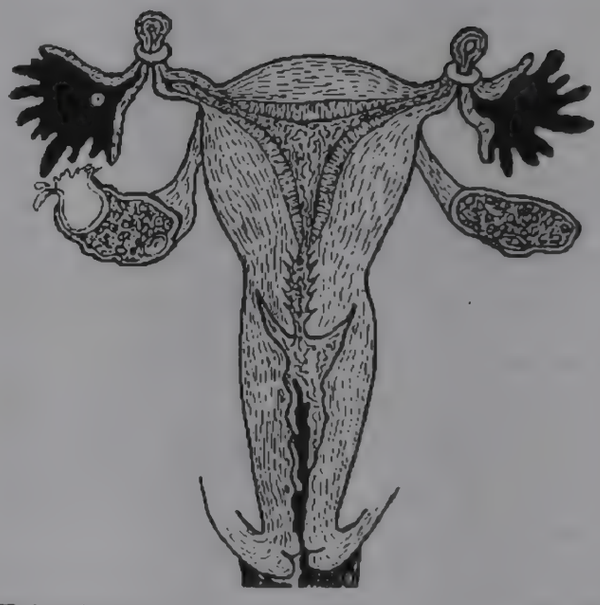
Whatever happens, women should be discouraged from getting this operation done in camp set-ups. Follow-up care and support is essential.

In ***vasectomy***, the sperm tubes are tied and cut just under the skin of a man's groin on both sides.

After the operation, new sperms are blocked from coming into the semen fluid. But, sperms already produced and stored in the semen sacs can stay alive for as long as three months. This is the reason some women have got pregnant after their husband's vasectomy.

Men who have opted for vasectomy confirm that there is no difference in their sexual function afterwards. Although vasectomy is a minor surgical procedure, it must be done with skill and proper care to avoid unnecessary complications like infection and pain. Compulsory sterilisations on men done during the emergency period has made the government cautious. Hence today, its policy mainly targets women.

Copper - T



Tubectomy

Non-Invasive Methods of Birth Control

We spent a lot of time to learn about safe, non-invasive, people-controlled methods of birth control. These we have included in our section on Fertility Awareness and Sexuality.

Abortion

The right to safe and legal abortion is a part of women's rights. All along, women have resorted to abortion as a form of fertility regulation. The term for legal abortion is ***medical termination of pregnancy (MTP)***. Although MTP was legalised in 1975, most of our PHCs do not have abortion facilities. Hence women still depend on unsafe illegal methods which can be fatal. Women's legal right to abortion is secure only in the context of population control. In government hospitals and clinics, abortion is done only if a woman agrees to insert an IUD or Norplant, or undergo tubectomy. Government doctors in PHCs and hospitals conduct abortions privately and charge high fees.

Lakshmi Narsamma told us about a tragedy near her home in Nellore District.

Sarojini was four months pregnant. She went to the ANM, who promised her an abortion if she would agree to tubectomy also. The operation was done in the PHC, and she was sent home the same day, without the MTP. Two days later she began to bleed. She was rushed back to the PHC. They kept her there for two days, just watching her. Sarojini died on the third day.

Pre-marital sex and teen pregnancies are on the rise due to social and economic pressures. Young girls who need abortion approach private doctors and quacks. They prescribe high-dose estrogen-progestrone drugs or ergot pills.

⇒ *E-P pills do not bring on abortion.* They merely bring on a period if a woman is not pregnant. But, if a woman is pregnant, they are known to cause defects in the foetus.

⇒ *Ergot may cause incomplete abortion*, without any arrangement to deal with the dangers.

With the new abortifacient drug ***RU-486***, women are going to feel that taking a 'pill' is better than going for a surgical abortion. They won't think of their already anaemic and weak state. When pregnancy occurs, the level of progestrone increases in the body. RU-486 acts by bringing down progestrone, creating conditions that are not suitable for the pregnancy to continue.

A few days after a single dose, bleeding starts, and sooner or later, the embryo is aborted. A recent newspaper article reported that a young woman in Bombay bled heavily after RU-486. Officially, the drug is still under trial.

The demand for safe and legal abortion may be viewed from two aspects. As a health issue, illegal abortions contribute significantly to women's ill-health and deaths. As a rights issue, a woman has a right to have pregnancy terminated in order to control her reproduction.

The question of giving training to conduct abortions came up once again.

Shardamma had missed her periods. From her life-story, Sathyavati thought she might be pregnant. But Shardamma kept on saying she couldn't be. After much coaxing, she agreed for a bi-manual exam. Sathyavati found her pregnant. Shardamma was very upset. She did not want this child, and she asked if we could help her.

Older women in the villages conduct abortions by inserting stems and giving uterine massages which later cause women lot of infection. We were in a dilemma. It was a felt need but we were not ready. Would we get support from the sponsoring organisations? Would the male project partners understand? Teaching them to do abortion could back-fire. Again we shelved it.

Abortion is not advised as a usual method of contraception. It often causes emotional pain to the woman. If one wants to undergo abortion one must do it as early as possible - preferably within five to six weeks of pregnancy. During an abortion, the foetus and placental membranes are removed from the womb. Depending on the length of pregnancy, different methods are used:

Menstrual Extraction: within four to eight weeks pregnancy. A tube that is connected to a suction pump is inserted into the cervix. With gentle suction, the contents of the womb are drawn out.

Dilatation and Curettage (D&C): for women who are eight to sixteen weeks pregnant. The cervix is dilated, the embryo is taken out and the womb walls are scraped clean.

Induction by Injection in the Womb: in pregnancy beyond sixteen weeks. A small amount of fluid surrounding the foetus is replaced by salt solution which causes contraction and expels the foetus.

That facilities for early detection of pregnancy and for safe abortion are not available is a grave violation of women's right to health and 'reproductive choice'. In the absence of safe facilities, women health activists may need to gain the skill to conduct abortions in early pregnancy. Our participants expressed this need over and over again. Although we had considered including it in our training, we haven't felt prepared, yet.

Women's Campaigns against Harmful Contra-ceptives

Since the eighties, women's groups have struggled against the government's population control policies. The present thrust is to obtain a ban on the development and use of *long-acting provider-controlled contra-ceptives*. Women's groups have intervened at local, state and international levels with the government, the scientific community, the multinational companies, funding agencies and the WHO.

In the early eighties in Hyderabad, *Stree Shakti Sanghatana* interviewed women who were getting ***Net-En*** during the clinical trial. The women had not been told that they were a part of a trial, nor had they been told about side effects. After learning about the health risks from the SSS activists, only five women remained. Stree Shakti Sanghatana, *Saheli* of New Delhi and *Chingari* of Ahmedabad together filed a writ petition about Net-En trials in the Supreme Court. The case has not yet come up for hearing, but even so, there have been two important outcomes:

⇒ guidelines and rules for drug-testing in India were introduced, and

⇒ the manufacturer didn't market Net-En in India, even though the Drug-Controller had given clearance.

Thus, for about ten years women in our country were protected from this hazardous contra-ceptive. Net-En has recently come into the market, after Depo-Provera.

Depo-Provera was introduced into the market in 1994. At Max-Pharma's launching of this contra-ceptive in Bombay and Delhi, women gate-crashed into the conference hall protesting against Depo-Provera being released. These protest demonstrations and articles in newspapers succeeded in raising an awareness in the public .

Norplant is now in its fourth phase of trials. Even though the trials have not yet been completed, the government now offers Norplant as one 'choice' in its cafeteria approach. This development is being closely watched by women's groups in the thirty centres where Norplant is available to women.

Anti-Fertility Vaccine (AFV) research is being carried out in various countries, among which India leads. At present, there is an international call by women's organisations for a halt on AFV research. Saheli of Delhi and *Forum for Women's Health* of Bombay, have been especially active in tracking the developments and disseminating information. The Women's Global Network for Reproductive Rights has called for a stop of research on AFVs. The reasons for this are:

- the potential for abuse on women and men,
- needless manipulation of the immune system,
- the unethical conduct of the clinical trials, and
- wrong priorities of contra-ceptive research.

Saheli and the Forum for Women's Health have taken up the promotion of this campaign in our country.

The campaigns have received support from two films made by Deepa Dhanraj, SOMETHING LIKE A WAR and THE LEGACY OF MALTHUS. Besides, other materials have been brought out by individuals and women's groups in form of pamphlets, posters and books.

New Initiatives

The Diaphragm: A group of women in New Delhi came together to form PARIDHI. This group focuses on re-introducing and popularising the contra-ceptive diaphragm. Their plans include information dissemination, a feasibility and acceptability study, marketing and distribution of new silicone diaphragms initially imported from Brazil. Eventually, PARIDHI intends to manufacture diaphragms.

Fertility Awareness Education: Groups are working to inform people how fertility awareness with or without barrier methods can be used effectively for birth control, if there is respect and concern between men and women.

The Female Condom: This is a new barrier method which protects a woman from both sexually transmitted infections and from getting pregnant. Despite some inconvenience, it is becoming popular with women in western countries who are glad to have control in their own hands. Howevér, once again, men escape their responsibility to practice birth control and to prevent spread of STIs. It is not yet available in India.

Efforts at birth control need to bring about non-violent and equal man-woman relationships, where men take equal responsibility for child-bearing and rearing. The government is fooling women that new contra-ceptives bring control into their hands and give them greater choice. It is not true. The hierarchy between men and women still remains unchallenged.

Body Politics and Beyond

Objectives

- to explore perceptions of the body
- to see the limitations of a reductionist view of the body and to look at the body holistically
- to familiarise women with outer and inner body geography
- to introduce the processes of ovulation and menstruation

Methodology

Sharing:	story of *Janthamani* memories of growing up...
Drawings:	female body and male body
Exploration:	*Body Mapping* *Live visuals*
Cut-out Puzzle:	body outline and inner parts
Pictorial Sheets:	physical growth at different ages sexual/reproductive parts ovulation and menstruation
Posters/Charts/ Cloth Scrolls:	female and male sexual & reproductive parts stages of growth in girls & boys feed-back tele-system ovulation and menstruation

Separation from Our Selves

Our upbringing in society affects our minds and bodies. Ideas planted in our minds of what is *normal* and what is *abnormal* mould both women and men. Women are supposed to be shy and beautiful, while men are supposed to be strong and handsome. With standards of beauty set by the world of men, a beautiful body becomes a focus of existence for women.

Other factors affect our bodies too, like work, food, clothing, education, sexuality, relationships, and restrictions of class and caste. How they mould and change our bodies could be seen in our participants.

They insisted I bathe only with cold water. I was always given curds and rice to eat, and nothing else - no spices, no chillies, no pickles or chutneys for me. Even now, I have the same diet. This was how they tried to crush my sexual desires. Allowing only bland food, making me work 'til I'm dead tired, sleep on the cold floor, cold baths always, dull white saris to wear... Even after all this, I have lots of desires,.... but I'm scared. What will people say? What will my sons say?

I am alone. I have to earn my living by working as a coolie on daily wages. Look at me - when I came here, you all thought I might be fifty, but I am only thirty-six years old! I'm sick and tired, but inside my spirit is still young. Tell me, what can I do to fulfil myself?

Look at our postures and physical make-up. When women's bodies are small, the commonest reason is lack of food because of poverty and deprivation since childhood. But shyness or timid behaviour may also be from growing up in oppressed conditions, as well as from gendered role prescriptions.

Keeping women ignorant about what our bodies really look like, and how they work and feel has long been a way of controlling us. Out-stripping social tradition, modern medical 'science' is busy building powerful myths. It medicalises and distorts our body functions. This makes us dependent on doctors, medicine and surgery and helps to maintain the power of male-dominated society.

The *male body* is projected as the standard human model, as if a female body is abnormal or deviant. From school and college, we see only male figures in the standard charts and textbook pictures. Important parts of women's anatomy and physiology are ignored or mis-represented. Alienating us from our bodies is the finest act of patriarchy. To counter wrong ideas and dispel our alienation, we need to explore and reclaim our bodies.

How Have Others Learned?

We looked at such attempts by other women to learn about their bodies. The book OUR BODIES, OURSELVES is an example of women in the west uncovering alternative health information for rediscovery of their bodies and psyches. Inspired by this *Anveshi*, a Hyderabad women's group, has written a book in *Telugu*, titled SAVALAKSHA SANDHEHALU ('A Hundred Thousand Doubts'). It is an effort to communicate experiences, insights and health information to women.

In Rajasthan, the state government's Women and Development Programme initially gave space to *sathins* to explore their bodies, reproduction and all the politics involved with it. In their book SHARIR KI JANKARI, they have shown us a new, sensitive way to depict women's bodies and body politics.

How does Modern Medicine see Human Bodies?

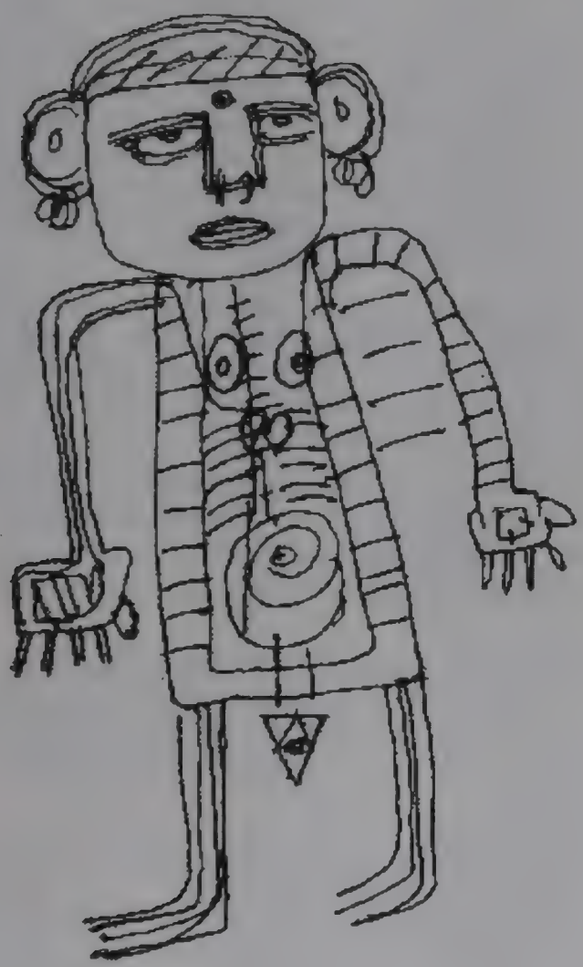
The modern western system of science and medicine is sometimes called *'reductionist'*. This means that it reduces the human body into separate parts. It treats the body as if it were a machine. The organs are classified into a hierarchy according to the importance given to their factory-like functions. Such a mechanistic and alienating view arose along with the industrial revolution and the 'age of enlightenment' in Europe just about two or three centuries back. Before that time, europeans had a *holistic* concept of the body, and they believed in its natural self-healing powers. Old ideas came to be labelled as *'unscientific'*. With the growth of capitalist economics, the mechanistic view became profitable as it enabled doctors to act as mechanics who fix and maintain bodies.

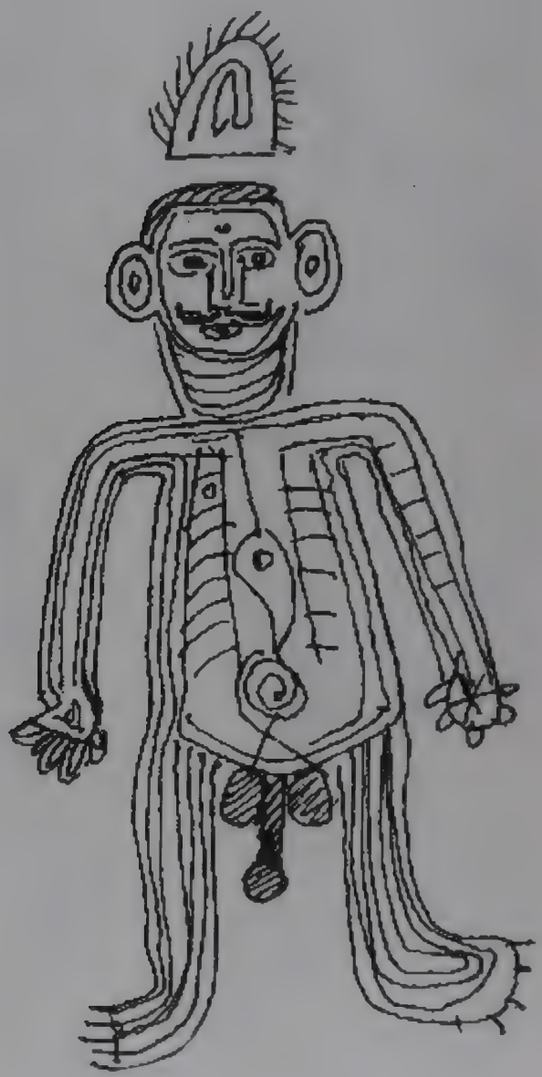
Traditional non-western cultures, with roots dipping thousands of years into the human past, all view the body from perspectives which are holistic, but the majority of them are also patriarchal.

How Do *We* Perceive Our Bodies?

We wanted to know how our participants perceive their bodies. We gave them paper and crayons, and asked them to draw the female body and the male body. Because of our experience with the role-play the previous month, we knew there was risk of the project women's perceptions distorting the sangha women's perceptions. So we divided them.

It was very interesting observing the two groups. Without hesitating, the sangha women clustered into three teams of three partners each. Although they were new to this activity, they confidently took up the crayons over the paper. As they worked, they discussed and argued about where the parts should be, and how they are related. They used the strong and bright colours confidently. In less than twenty minutes each of the three sangha groups had drawn out a female body. The male followed shortly after.





Meanwhile, for a long time the three groups of project staff women were blank. They went looking for pencil and rubber. They prepared rough diagrams in their notebooks and were rigid about lines. First they drew a body outline. Two groups then put in breasts and vagina. The systems like digestive and urinary and lungs and heart got illustrated separately outside the body, trying to recall school text-book diagrams. The other group put clothes over the body and gave stress to extrinsic details like earrings and purses. They took three-fourths of an hour for this and did not feel free to draw the male body.

We gathered ourselves together to analyse the drawings. The sangha women began. In all the three sets of drawings, both the female and the male body were bold and colourful, and equal in proportion. Each group expressed a regional and cultural style - possibly *lambadi, enadi* and *dalit*.

They spoke about the drawings, each seemed to have a consistent logic. They gave importance to heart *(gunde)* and brain *(medhadu)*. They said,

We love with our hearts, and the heart sends blood to the brain.

The brain is the storehouse of our memory. We can't read or write. You depend on your books, but we depend on our memory.

Another area prominently drawn and coloured was the ribs. *Why?* we asked them, and they said,

We often see our ribs. They stick out. Our children are thin. All we see is their bones. This is our poverty. We see and feel the ribs every day.

Then, the mouth was directly connected to an intestinal labyrinth, and there was no idea of a distinct 'stomach'. The vulva-and-vagina *(yoni)* was given an important place. In the male body drawings, the penis *(lingam)* with testicles was given the same importance.

It was now the project staff's turn to show their drawings. Hesitatingly they began. Looking at their pictures, the sangha women grew restless. Not giving the others time to explain, they set upon them with questions.

Why have you broken up the body? Do our bodies consist of only breast and vagina? Could our intestines be separate from the body - why have you drawn them outside? Are we not whole beings?

Seeing that one of the drawings was clothed in salwar-kameez (punjabi suit), they laughed teasingly. Actually, these drawings did seem distracted, and we also felt they lacked colour and creativity.

It was difficult for the project staff women to accept this criticism. They thought that what they were trying to reproduce from textbook learning was superior. It took them sometime to get over the criticism. Everyone made an effort to diffuse the tension. We reflected on how formal education has alienated us from our bodies, how it has blocked our creativity, and how we have absorbed the messages from the media.

Body Mapping and Puzzling

The drawing exercise had explored our ideas of our body. Now, we did 'body-mapping'. One volunteered to be the 'body'. She removed her blouse and loosened her sari, lowering it from her waist. Kranti picked up a lipstick as a marker and slowly drew outlines of the internal organs over her chest and belly.

We started with the passage of air through the nose, down the wind-pipe to the lungs. The ***lungs*** take up the space in the chest on both sides, within the rib-cage, leaving space in the middle for the heart. They take in oxygen from fresh air and purify the blood. The ***heart*** constantly pumps blood, getting it fresh from the lungs and sending it to all the other parts of the body. In return, the heart takes the used blood from the body and sends it back to the lungs for cleansing and re-filling with oxygen.

The ***brain*** occupies the upper round part of the skull, behind the fore-head, behind the ears, down to the top of the neck. With our brain, we receive messages in the form of sensations, and we respond by conscious or unconscious activity in our body. It continues with the spinal cord down a canal in our back-bone, out of which pass all the nerves.

The ***liver*** takes up space under the right lung, below the ribs. It forms much of the blood content, and produces bile (*pitha*) which helps digest food. It de-toxifies harmful substances. When we are under stress, the liver helps us to mobilise strength and energy. The ***spleen*** takes up a similar but smaller space under the lungs and ribs on the left side. It's main job is to filter out the blood.

We came back up to the *mouth*, connecting it with the *food-tube* which passes down behind the *wind-pipe* and the heart. The ***stomach*** is a large, expandable sac continuing from the food-tube as it comes out below the heart and lungs. It collects the food and liquid we eat and drink, mixes it with digestive juices, and holds it for a time. The ***small intestines*** in the middle of the belly receive partly digested food in small portions from the stomach, and carry it on a 23-foot long journey. The nutrients get absorbed in the blood and taken to all parts of the body. The remains of the fully digested food passes into the ***large intestine*** in the lower right corner of the belly, travelling upwards along the side, across, down the left side, to come out as faeces at the anus. The urinary ***bladder*** was marked in front, above the pubic bone, with the ***womb*** above and just behind it.

Turning around to the back, we marked the ***kidneys*** on both sides, in the angles formed by the back-bone below the last ribs. They maintain the balance of salts and water in our body, and filter out un-needed substances.

To get a better idea of *internal placement and movements* of these organs, we tried ***exploring for signs***. We looked for movements on the body surface, felt for expansions and pulsations, tapped for sounds of hollow air spaces or dullness and in the end put our ear over parts of our companion's body. We could hear the sounds these organs produced - air flowing in and out of our lungs, the heart pounding as it pumps our blood, gurgling intestines digesting the food we'd eaten. We learned to feel the pulse at each-other's wrist, too.

To strengthen our grasp of the placement of organs, we did another exercise involving a ***paper cut-out puzzle***. Each small group was given a paper sheet with a printed body outline and another sheet with organs printed on it. The body outline had slit-marks for insertion of matching tabs attached to each organ cut-out. Scissors and blade were used to make the cut-outs and slits. Then, the women had to fix the different organs into the body outline, one by one - over-lapping and inserting parts between or underneath each other as appropriate, and according to the matching tabs and slits.

Back in the larger group, we repeated this with a ***full size body cut-out*** and actual organ sizes. The participants became confident in placing most of the organs and describing their relations with each other, and their basic functions.

The Hormone-Secreting Glands

After a break, we re-started. We considered the set of small but important organs called *glands (granthi)*. These we located by charts, and we also traced them over our bodies -

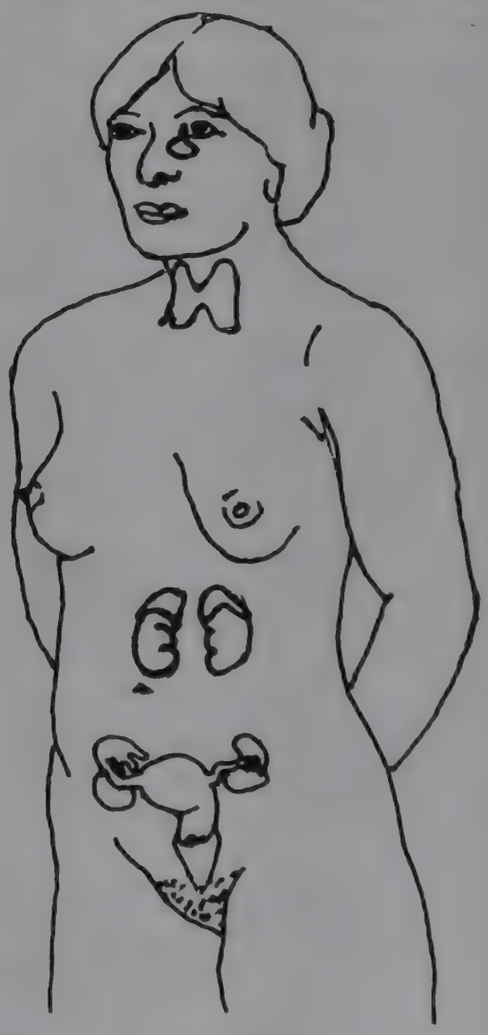
pituitary (1)
thyroid (1)
adrenals (2)
ovaries (2),

All these glands secrete natural chemical substances called *hormones* which cause changes in the body. The ***pituitary gland*** is like a tiny bean or pea-shaped bundle hung by a stalk just below our brain, in the middle of our head. The pituitary is like a co-ordinator. It secretes several different hormones, most of which work by stimulating the other glands, like thyroid-stimulating hormone, adrenal-cortex stimulating hormone, and ovarian-follicle stimulating hormone (known as *FSH*).

The ***thyroid gland*** is in our neck over the wind-pipe. Sometimes in some people, when they don't get enough *iodine*, the thyroid enlarges and we call it 'goitre'. The thyroid's most important work is regulating our body's production and use of heat and energy through the hormone *thyroxin*. If the thyroid is over-active, our body produces too much heat, our heart beats too fast, and we get nervous and fearful.

The ***adrenal glands*** are on top of each kidney. They produce hormones which make us grow, and which make our body respond under pressure or stress. For example, when we get sick or injured, adrenal hormones called 'steroids' help our body to heal quickly.

The ***ovaries*** are glands which produce *seed-cells* (or *eggs*) along with their hormones. We shall learn more about this later.



Glands Which Secrete Outside

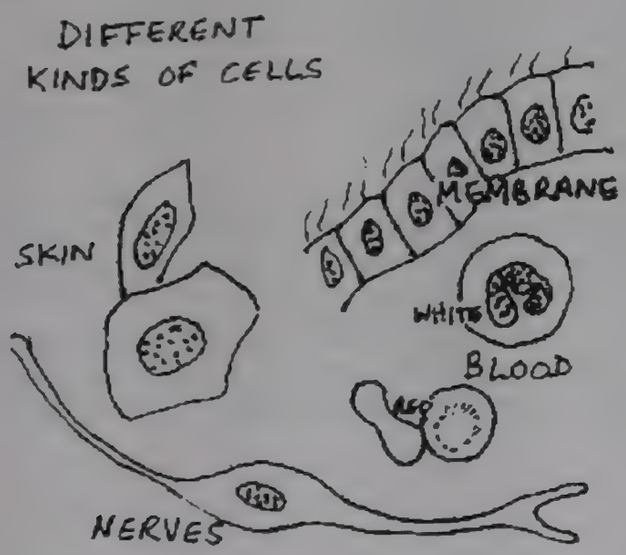
The hormone-secreting glands send their secretions into the blood to carry their messages and regulate our body's functions. But other glands are spread all over our body, and they secrete substances for various different purposes -

sweat and oil-secreting glands in our skin
tear-glands in our eyes
saliva glands in our mouth
mucus glands in our nose
intestinal glands that secrete digestive juices
mucus-secreting glands in the womb
acid-secreting glands in the vagina,
and so on....

These secretions are protective, and sometimes communicative.

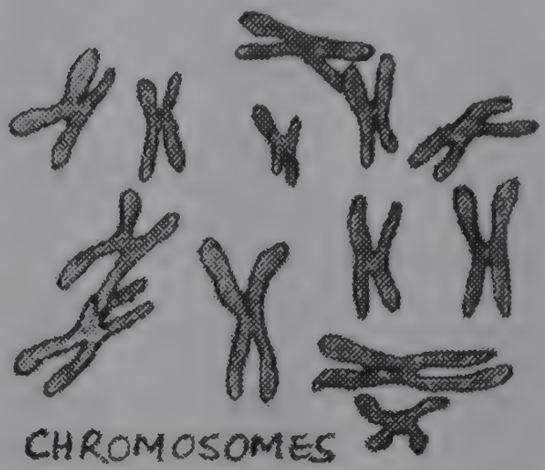
Cells and Chromosomes

We took a little time to get familiar with the smallest parts of our body - ***cells***. Many, many of these tiny living units make up our body tissues. Cells are of different kinds, but each one of them performs similar basic functions needed for its survival. Also, the different kinds of cells perform special activities in balance with the surrounding cells and the rest of the body - for example, blood cells, nerve cells, muscle cells, fat cells, sweat-gland cells, etc.



An important and fascinating thing about every cell is that the cell's *nucleus*, or centre, carries a full set of information about one's whole body, like a map or kind of guide-book! The information is actually coded in tiny rope-like strands called ***chromosomes***.

There are forty-six chromosomes arranged in twenty-three pairs. We all get a half-set of chromosomes from our parents.



Our cells come together to form different kinds of tissues, according to information coded in the chromosomes.

Common Parts and Tissues

We moved on to explore tissues and substances which *draw our body together* to preserve and protect us and to *communicate* within our-self, and between us and others.

Smooth or rough***skin*** covers our whole body. It is the physical inter-face between us and our surroundings. We looked at our skin, and felt it.

The skin of my hand is rough - it is hard from the work I do.

The skin over my face and body is wrinkled and dried after the hard-ships I have endured - my hair is white, though I'm only thirty-eight.

At the end of the day, I don't like to sit close to anybody - I feel my skin stinks of sweat.

Water makes up about 60 percent of body weight - as fluid in our blood and in all our tissues. Water is important to maintain the body's balance.

When I haven't drunk enough water, I've noticed I get dark-coloured urine, and it feels burning and hot...

Lakshmi Narsamma quipped,

Ah! Now I know I'm not fat - it's water in my body!

Blood flows constantly, circulating through our whole body, pumped rhythmically by our heart.

Feeling the nadi - is it the heart-beat?

Seeing the blue veins raised up on our hands, we imagined the channels of blood running like rivers through our bodies.

The blood-stream is a carrier of many things - life-preserving oxygen and tissue-building nutrients, hormonal messages, and protective substances. It collects and conveys used and unneeded substances, enabling them to be excreted from our body through urine, sweat and the air we breathe out.

Blood is mis-believed to be a carrier of presumed social traits - hence, we hear people talking about 'good' blood and 'bad' blood, language which conveys class and caste-based or racial prejudice.

Networks of **lymph** nodes and channels are routes for drainage of unneeded fluid and other substances from the tissues. The nodes swell in their attempt to block the spread of harmful elements, like microbes and cancer cells.

Our Body Co-ordinates...

How do all these cells, tissues and parts work together, so that our body is one?

Under natural circumstances, all the parts of our body work together in harmony, so that we are comfortable, active and productive, and we can meet ordinary stresses and challenges easily. While all our tissues play their part, it is mainly the combined actions and connections between nerves and hormones which co-ordinate body activities. Thus, the brain-and-pituitary-gland on one extremity are linked with various tissues and organs, and on the other to nerve reflex and hormonal feed-back net-works or 'tele-systems'. Such neuro-hormonal reflexes are even involved in regulating immunity. Later, we will be exploring in detail the neuro-hormonal tele-system involved concerned with regulating and modulating our sexuality, fertility and reproduction....

Resists...

The air we breathe, the food we eat, the water we drink, and our social relationships help our body to strengthen its self-preserving and protecting processes. Our skin, the hair and mucus membranes help protect us by obstructing the entry of harmful substances and microbes.

I can feel hair inside my nose - on my eyelids - inside my ear...

Sometimes, harmful microbes are able to enter our body and pose a threat to our balance. It may be because of an injury or because of unsafe activities.

The body cells identify these outside elements and create substances called *anti-bodies* to single them out, to stop their over-growth and neutralise their disruptive actions. Anti-bodies are carried through our blood and in other body fluids, including breast-milk. This preserving and protecting activity of our body is known as ***immunity***.

...and Communicates

Our body communicates within itself and also with our environment.

Effects within our body are brought about by a communication network of nerves and hormones. What happens outside us stimulates various responses within us, too.

The *nerves* co-ordinate the motions of our body. They transmit sensory and motor messages to and from different body parts. Suddenly, Saroja piped up,

Oooh! I pinched the nerve at my elbow - it's like a current of electricity!

Ramalamma threw a piece of chalk at Nagamma, who turned to her in surprise.

A fly came in and sat on Pushpa's nose - she flicked it away, unknowingly.

Vasantha laughed, and said, *Pushpa, you didn't even realise...*

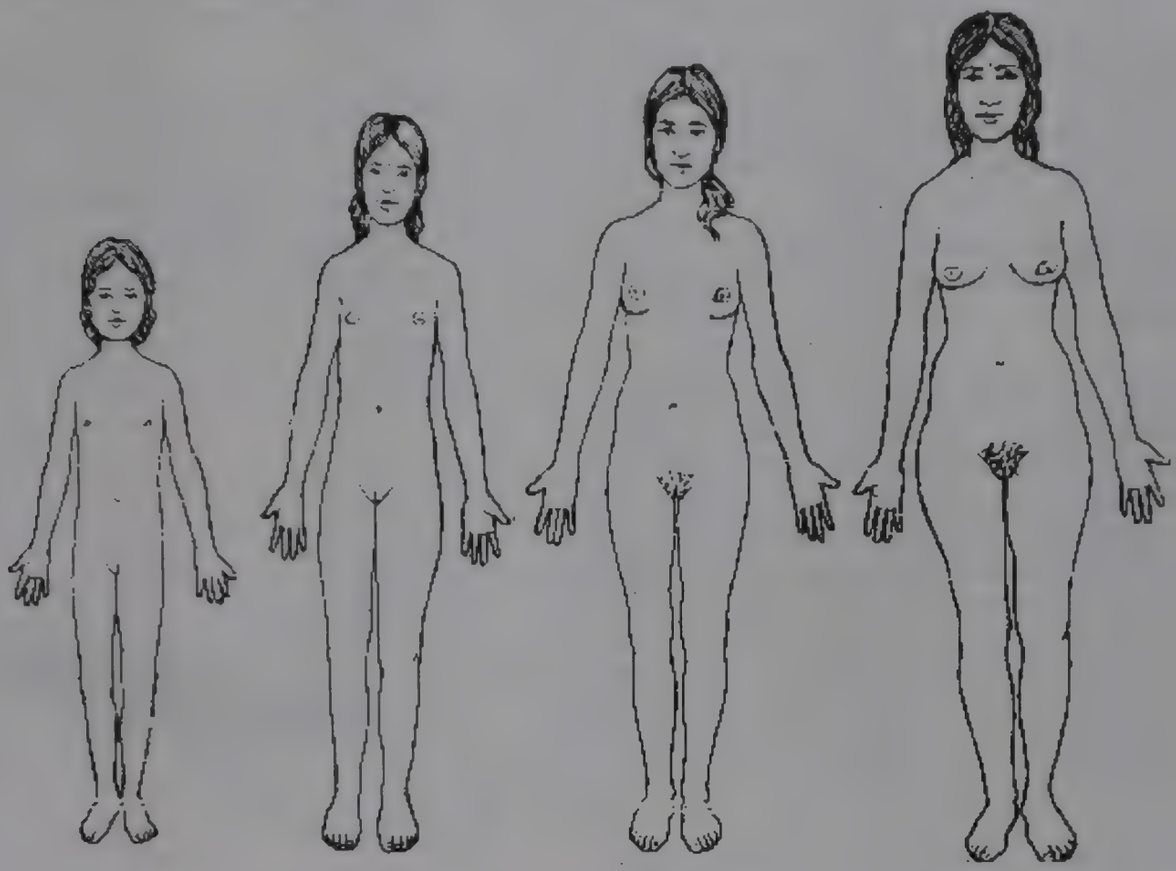
Consciousness is a quality of our ***mind***. ....not separate from our body, and others' bodies. It develops within social surroundings, structured by society.

A radical change in consciousness comes about in girls and boys at puberty. During these years, they become profoundly aware of their bodies.

The Awakening of Sexuality and Fertility

Getting enough good food while a child grows up is important in bringing on *puberty*. This is especially true for a girl, since having some fat in her body enables her to make the natural hormones which bring on the body changes.

Keeping in mind the experience of child-marriage among our participants and its prevalence in most parts of Andhra, we focused on the growth of girls' bodies. With the help of a large pictorial chart, we compared the physical development of girls in four stages - at ages eight, twelve, sixteen and then eighteen.



At puberty, external and internal changes take place in a girl's body. These changes take place because of the effects of *estrogen*, one of the two hormones secreted by the ovaries.

- ⇒ her bones and muscles grow stronger
- ⇒ some fat is stored in certain places
- ⇒ hair grows in her armpits and over her pubic area and vulva
- ⇒ her breasts grow and become sensitive
- ⇒ her vulva and the internal genital organs develop, and
- ⇒ her ovaries start to produce eggs and hormones, so her menstrual periods start.

Every girl develops differently, and at her own pace if she is given a chance. After menstrual periods begin, the body usually takes about four years to get completely ready for reproductive functions.

At the emotional level, too, there are changes. A girl becomes aware of her body developing. She has new desires. She may crave to be loved, to be appreciated and assured. She wants to be 'someone'. Powerful sexual urges arise within her, also, which she doesn't understand but she is taught to feel shame for.

... and Real Life

In rural Andhra Pradesh, girls are married off as children. Some are sent early to the husband's place, where he starts relating to the child even before she gets her periods. After that, the girl is pressed to bear a child within the first year. If she does not, she may be taken and left at her mother's home. There is no sign of the husband, and the girl is deserted with no future. Sometimes she hears he has married again.

For those girls who do conceive in the first year, it is at a terrible cost of endangering their lives. With small bodies and undeveloped parts hardly able to hold a foetus, it frequently results in miscarriage or very difficult child-birth.

We told the group a tragic story of a girl who paid *both* prices. It was about Janthamani, a member of a *pillalu sangha* (children's collective) in Medak District.

> Janthamani was just ten years old when her grand-mother got her married. She had no parents. When she was twelve her periods started, and right away she got pregnant. In the sixth month, her husband abandoned her back at her grand-mother's house. Soon after, when her grand-mother was out working in the fields, Janthamani started feeling pains. She didn't know what was happening. All in the village were away at work. In the after-noon Janthamani gave birth to a premature baby. She went into mental shock, not knowing what to do until her grand-mother returned.
>
> It was evening. We rushed to see Janthamani at her grand-mother's house. Even then, she was stunned, unable to talk. Examining her, we were horrified to see how tiny her vaginal passage was, how under-developed her other organs must be, leave aside her poor general health. We wondered in anger, *Was he an animal who did this to her?!*

As a mere child, Janthamani had been burdened with proof of her fertility. This incident shook up our participants who had young daughters. Subbamma's daughter had just matured. She cancelled a marriage proposal, asking the intended in-laws to wait for another two years.

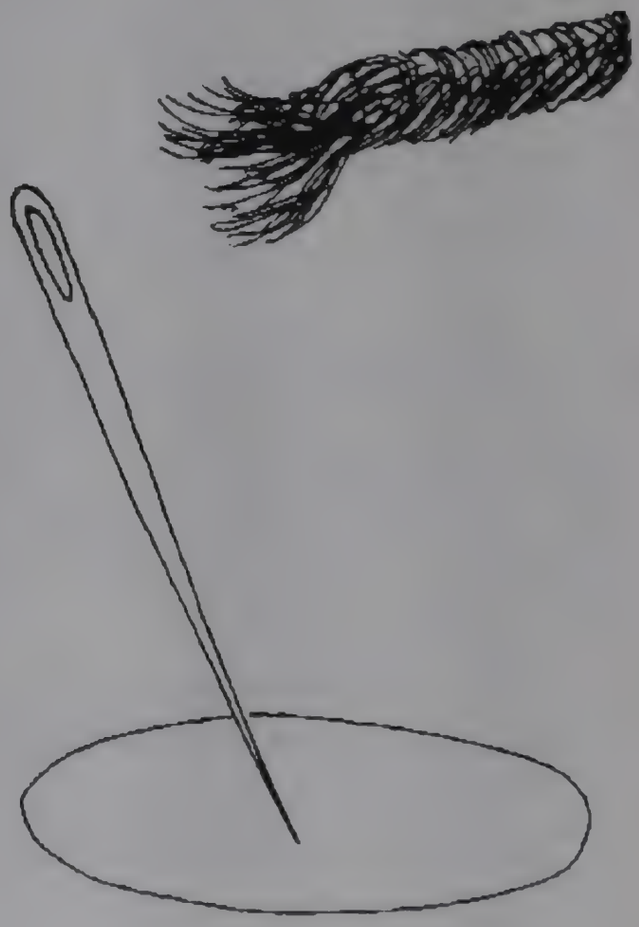
I realise now, my daughter is not a burden to me. I don't want to spoil her future by sparing myself the tauntings of the others. This training has taught me a lot of lessons. I need to begin with myself, if I have to change this evil practice in the village.

We discovered that some mothers give their daughters pills to bring on periods, and then send them to the in-laws' house. Sathyamma shared,

I got my daughter married before her periods came. Usually, we keep our daughters at home until they grow up. But I sent her to the in-laws immediately after marriage. Her husband use to want sex often.

I asked the chemist for some pills to bring on her periods, and I gave them to her. Now I know better. I feel very bad about what I did.

When our participants thought and compared a girl's body at eight or twelve to her body at sixteen and eighteen, they realised how they had violated their children by getting them married at such a young age and pressurising them to bear children. But, this new personal awareness would have to withstand the whole *complex of social pressures* - subtly controlling the labour, property, fertility and sexuality of women - which perpetuate child marriage.



Boys' Puberty: Changes also take place in boys which start usually between ages eleven to thirteen. The *pituitary* gland, in his head below his brain, sends a stimulating hormone through his blood to his *testicles*. These glands begin to produce sperms and to secrete *testostrone*, the male sex hormone. This hormone causes changes like growth of hair on his face and body, deepening of his voice, his muscles becoming strong and his bones heavier. It also makes the male genitals grow. He is surprised by getting erections, and that semen sometimes comes out during his sleep while he dreams.

He may become emotional and sensitive in a new way, and he starts to have sexual feelings. This phase of life may be stormy. He is in great need of wise guidance and proper information about sex and fertility, but this he almost never gets.

Puberty changes go on for five to seven years or more.

Our Sexual and Reproductive System

Since women have been discouraged from touching, or even thinking about, the mysterious area 'down below', they often feel quite uneasy about it. They regard this tabooed region differently, and it needs special effort. We need to learn about men's bodies too, if we are to understand sex and reproduction and to expose some myths about males. The older women would crack jokes about male genitals. A spirit of anger was not hard to detect. But the younger women were as knotted up about male bodies as they were about their own.

With the help of pictures we looked at the male and female bodies. One said,

There is not too much difference - men and women both have a head, two hands, two legs. We have most of the same organs inside. Only the genital parts are different. Then, how come men are more violent?

Features of Both Sexes

Let's look more carefully at the sexual and reproductive systems of men and women -
how are they different, and how are they alike?

⇒ The *onset of puberty* differs by about two years - around nine to eleven for girls and eleven to thirteen for boys.

⇒ Sexual and reproductive function in both women and men is regulated by the *pituitary gland,* which is inter-connected with other organs through a kind of 'tele-com' system linked by the blood and nerves.

⇒ Both sexes have a pair of *genital glands*, the testicles and the ovaries, which secrete *sex hormones* and produce *seed-cells* - sperms in men and eggs in women.

⇒ Both have *erectile organs* of sexual response, the *clitoris* and the *penis*.

⇒ In both male and female, *aggressive feelings* can arise with sexuality, but it is socially suppressed in women and supported in men. Likewise, feelings of affection can arise in both, but are cultivated in women and rooted out of men.

An out-standing difference between men and women is in the nature of their *fertility*. In men, it is *relatively constant* from teen age to old age. In women, it is *interrupted and cyclical*, from teenage to middle-age.

⇒ Only women can produce and *give birth* to children, and *make milk* to feed them - and, during menstruation, women can *bleed without injury*.

⇒ *Only men have Y seed cells which determine the sex of a child*, as we shall explain later.

A Man's Sexual and Reproductive System

Having a more limited role in biological child-bearing, the male sexual and reproductive system is simpler than the female.

The Male Genital Organs and Tissues: Slung outside the body in a skin-and-muscle pouch, the ***testicles*** respond to stimulation from the pituitary gland. They are *cooler* than inside, because producing sperms requires a temperature lower than the inside of the body. Each testicle is made up of about three hundred tiny compartments with soft, tightly coiled tubules, where millions of sperms are produced. The ***sperms*** take about sixty to seventy days to ripen to maturity.

Then two ***sperm-tubes*** (one from each testicle) pass under the skin over the pubic bone and enter the belly. Inside, they go over and behind the urinary bladder.

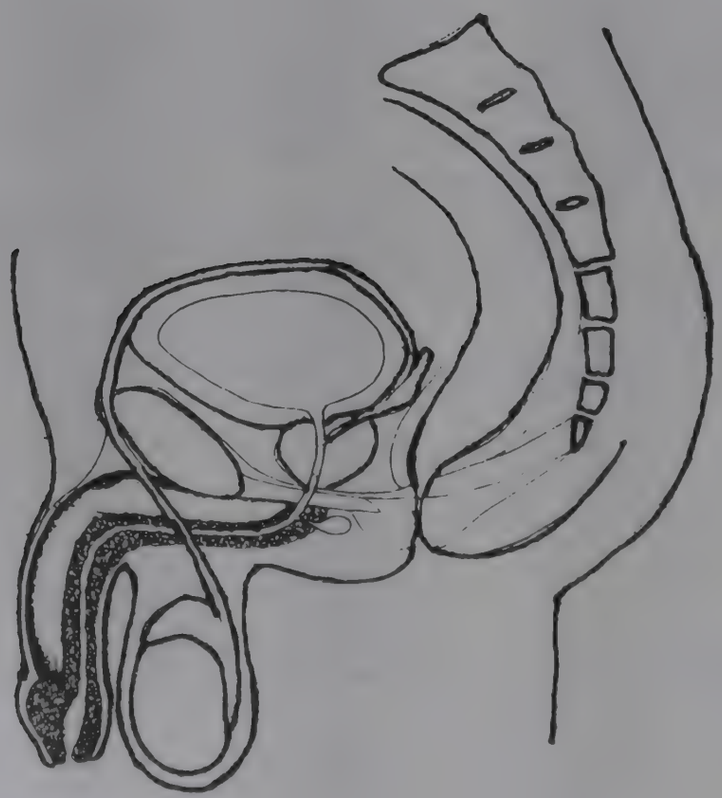
There, the sperms get stored in two ***semen-sacs***, where the sperms get mixed with a slightly alkaline fluid that feeds them and keeps them strong. This mixture of fluid and sperms is known as *semen*.

Two semen tubes then pass through the ***prostate*** gland and join the *urine tube* which passes from the bladder into the ***penis*** and opens to the outside at the end.

The penis allows urine to come out, and ejaculates semen during *orgasm*. But, both things don't happen at the same time! When a man's penis is erect and he gets an orgasm, a small ring-like muscle contracts at the base of the bladder, stopping the urine.

The tip (or ***glans***) of the penis is sensitive and is protected by a loose hood of skin (the ***foreskin***). The inside of the penis has soft spongy tissues surrounding the urine tube. When a man feels sexually aroused, the *sponge* fills tightly with blood and his penis becomes erect and firm.

Male Body Politics: Some males are muscular and heavy in build. A common belief is that *aggressiveness* and *sexual promiscuity* are rooted in male biology. This belief is wrong, but it used to justify domination and oppression of women. Given the same opportunities and privileges as men, women can also develop to their full potential.



Woman's Sexual and Reproductive System

When we studied the male system, we had to depend on pictures - here we could have ***'live visuals'***!

Medical textbooks misrepresent and distort the female body, especially the sexual and reproductive parts. The vagina is always shown as a gaping hole or an open tunnel. The clitoris, if ever mentioned at all, is pointed out as a small bump. Both of these ideas are wrong. Likewise, there are myths about orgasm. It was said that a mature woman will have an orgasm centred in the vagina whereas an immature woman's orgasm will arise from the clitoris. Furthermore, the idea was promoted that women's sexual response needs stimulation by a penis. Such myths have done a lot of harm to women. They have affected the behaviour of both men and women.

Lets look at ourselves:

We looked at our ***breasts*** first, in front of a large mirror.

First, we noticed that we don't have the same size and shape. Often the right one was smaller than the left. In the middle of the breast we noticed a circle of darker skin. Some had firm nipples while some were puckered. One had a deep pit in her right breast, a scar from an old abscess. Another was shy of her large breasts, and a third felt that her chest was too flat. They were all ashamed. The breasts of some of us sagged, while others' breasts were firm. We wanted to know, *Why?*

Over the years, the breasts droop as a woman's skin and inside structure becomes looser. During childbearing and breast-feeding, the breasts enlarge and stretch the skin. At the middle of the breast we could see a ***circle*** of darker skin with a ***nipple*** in the centre.

Some of us had nipples that stuck out, and others had flat ones, or even pushed a little inside. We felt the nipple and the circle with our fingers. The dark circle was soft and spongy. Some had nipples that were hardened and lengthened from breast-feeding an infant for a long time. As we were feeling with our fingers, some of us noticed that the skin puckered and the nipple stood out. It felt *tickly* and *tingly*! This had happened, too, when we've been cold or when we've been sexually excited.

Now we wanted to learn about what the breasts are like inside. From the picture, we could see how the inside of the breasts consists of fat, fibre tissue and milk-producing sac-like ***glands*** and ***ducts***. When a woman breast-feeds her child, these ducts carry the milk from the gland-sacs to the nipples. When we go through puberty and our ovaries start secreting the hormones estrogen and progestrone, our breasts grow. During each menstrual cycle, our breasts change, becoming larger, heavier, and rounder and then smaller again. During child-bearing, our breasts grow and develop to feed the new-born child.

Among our ***'lower' parts***, the participants called the vulva *'manam'* or *'yoni'*, the vagina as the *'yoni margam'*, and to the womb as *'garbha sanchi'* (the bag that holds the embryo).

We gave them paper and colours and asked them to draw pictures of the manam and the reproductive parts, not as they might have seen them before in charts, but as they understood them from their cultural background.

The women used a lot of bright colours - red, green, orange, yellow, purple. Although the drawings did show the influence of pictures of the reproductive organs that they had seen before, the forms and symbols they used to express the vulva and the womb were of bud, flower, almond, coconut. Within the vulva, they drew three 'o's.

Live Visuals

Then, we put up on the wall a blown-up text-book picture of the vulva. But the women looked puzzled. Only Nageshwari, Vasantha and Subbamma told us that it was the picture of the *yoni*, but no more than that. Then Sabala suggested, *Why don't we look at ourselves?*

The room filled with gasps and 'Aiyoo!' When we had done body mapping, we'd been so careful not to go beyond three inches below the navel, clinging to our clothes. Everyone of us tightened up. No one was prepared to take the lead. We understood that we had to allow time and space to each of the participants until she was ready. So, one of us decided to give the lead. With determination, she took off her salwar. Sitting and leaning against the wall, she spread her legs apart. Holding the mirror in front, she separated the inner lips of the vulva and explained the parts within it.

Some of the women came near, peeping from the sides. The parts inside the vulva were pink, but not very clear. With the fingers of her other hand, she started to feel and locate the different parts. One broke the silence, laughing,

Why are we so scared? We're all women. We don't feel shy with our men! See, it's so easy!

Still standing, she lifted her saree and felt her vulva. Then, she exclaimed,

Here! I've found my santosham button'!

This loosened up everyone. One, who had suppressed her sexual urges since the age of fifteen, could hardly wait to see herself. But she was nervous. All the do's and don'ts shouted inside her head. She kept looking to us for assurance. Sitting next to her, Lakshmi Narsamma stroked her back while she went ahead. Once she had broken her taboo, she relaxed. The rest of the sangha women needed no coaxing to look at themselves.

Pushpa was most open among the project staff women. But the others were literally shivering, so we gave them more time. Gradually each one took a look at her own vulva. We felt the most sensitive part of the clitoris. We all touched the urinary opening, vaginal opening and anus. Then, we looked at each-other's vulva...

My husband expects me to remove the hair. I take a lot of time rubbing with ash and stone to remove it.
I was surprised to see today that many of my sisters have hair on their manam.

I never knew I was so pink down there. I was always told that it is bad to look at my manam.

I was feeling ashamed in front of you all. I always thought my manam was too big.

The group was now relaxed. They saw that just as each one's face is different, the vulva has different colours, size and shape, too. Discovery of diversity in our bodies is important, as it helps us to value ourselves. It breaks down the norm of an 'ideal' body.

We encouraged the women to keep on exploring. Alone, some ventured to stimulate the clitoris to orgasm. The next day one of them said,

I don't need a man to satisfy me! I can do it to myself. And, just think - all these years, this button was hidden from me!

The Vulva-Yoni -Clitoris

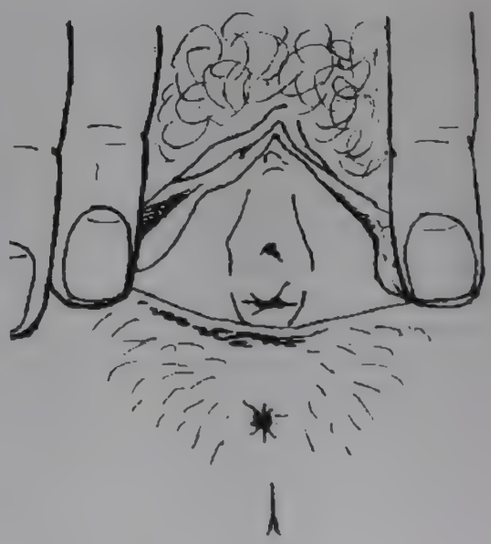
The term *vulva* corresponds to *yoni*, or *manam* as our sangha women called it. In a narrower sense, the yoni may be located as the vaginal opening within the vulva. The yoni is also an ancient symbol of feminine regenerative power. Taking a new view of the *clitoris*, we can understand it also to be nearly the same as the yoni. Our participants discovered it's most sensitive part - the *glans* - as their *santosham (pleasure) button*.

Until recent times, doctors have either ignored the clitoris entirely, or they believed it to be only a sensitive bump. But in every regional language, there is a name for it. Using the word *santosham* itself recognises its role. Today, we know the clitoris is much more than a button or bump - in addition to the glans, it has in-reaching spongy tissue which swells during excitement and muscles that contract during orgasm. Fine networks of nerve fibres and blood vessels stretch back and in around the vaginal opening and the urine tube.

The hairy padded outer lips of the vulva protect the sensitive *clitoral structures*. The thinner ***inner lips*** are hairless. Veins can be seen through the thin skin of their inside fold. Their colour varies, from bright reddish or pink on the inside to deep brown or black on the outside. They also vary a lot from woman to woman, in size, colour and texture, and can be large or small compared to the outer lips. They enclose other clitoral structures, including the vaginal opening and the urinary opening. Deeper inside are spongy masses which fill with blood and swell.

The inner lips join in front over the ***clitoral glans*** and ***shaft*** forming a ***hood***, varying in appearance from one woman to another. With the flat of our fingers in a circular and back and forth motion, we felt above the hood to find the shaft of the clitoris. Below the hood and glans is the ***opening to the urine tube*** which leads to the bladder. This opening is often difficult to see because it is small and slit-like. The urine tube opening can be very close to the ***vaginal opening***. Within the vaginal opening is the fringe-like ***hymen***. On either side towards the back of the vaginal opening are two ***vulvo-vaginal glands***. We only notice them if they get infected and become swollen and painful. Behind the vagina, beyond the clitoral area, is the perineum and the hairy area surrounding the anus.

Being very sensitive, the clitoris can be stimulated to reach orgasm in all sorts of gentle, non-penetrative ways. Modern feminist health research has re-defined the ***clitoris*** as *all the structures which function together to produce orgasm.*



The Brain, the Glands and the Hormones

When we think of the sexual and reproductive system, we must never forget two parts at the base of our brain - the *hypothalamus* and the *pituitary gland* just below it. They play a vital role in regulating and modifying sexual and reproductive functions through nerves and through hormones.

Being a part of the brain, the ***hypothalamus*** is influenced by our thoughts and emotions, and by any kind of stress. It is in close contact with the pituitary gland through tiny nerve fibres and blood vessels.

The ***pituitary gland*** makes two hormones important for fertility and sexuality,

- follicle stimulating hormone, or *FSH,* and
- luteinising hormone, or *LH.*

It also makes two other hormones - *oxytocin* and *prolactin* - which contract the womb muscle after child-birth and produce milk during breast-feeding.

The hypothalamus stimulates the pituitary gland to secrete FSH and LH which in turn stimulate the ovaries. The *ovaries* secrete their own hormones called estrogen and progestrone.

Estrogen brings about changes in our emotions and bodies - it heightens sexual desire, makes the sexual parts more sensitive and lubricative, and causes the cervix to produce mucus which protects the sperms, while an egg gets ready. It also builds up the womb lining.

Progestrone gets ready for a fertilised egg to be protected, implanted and nurtured - it turns off or lowers sexual desire, makes the womb lining thick, soft and nutritious, reduces womb muscle activity, and makes the mucus into a thick plug blocking the canal into the womb.

The levels of ovarian hormones affect the hypothalamus through *feed-back*. The hypothalamus is affected by *negative* feedback from low levels of estrogen and progesterone. The pituitary is affected by *positive* feedback from the peak of estrogen before ovulation.

The relations between the brain, the glands and the sexual and reproductive parts forms a kind of *neuro-hormonal tele-system* which regulates our sexual and reproductive functions. These functions are cyclical. Our cycles respond to various kinds of stress like excitement, worry, illness, and hunger.

The Ovaries

The two *ovaries* are glands on either side of the womb. Most women are not aware of them. The ovaries are sensitive, and painful if pressed. Each ovary is about the shape and size of an almond. Suspended within the ring of our pelvic bone, they rest within the broad-ligament which binds our womb to the bony wall. Above them run the egg-tubes with finger-like ends reaching over each ovary.

A girl is born with about *a million* unripe egg-cells in her ovaries. These stay inactive throughout child-hood. At the time she gets her first period, she has around *two lakhs of* unripe egg-cells. Several egg-follicles begin to mature together in each menstrual cycle, but only one ripens completely.

When an egg-cell gets ripe, it breaks out of a follicle on the surface of the ovary. This is called ***ovulation***. Often we can feel ovulation when it happens as a brief, pricking sensation or pain. After ovulation, the empty sac of the burst follicle changes into a small micro-gland, the *yellow body*. Then, after about ten days, the yellow body shrinks, and the menstrual period starts.

The ovarian follicles do more than just produce egg-cells - they produce estrogen and progestrone. Every month, *estrogen* and *progestrone* cause cyclical changes in our body.

The Egg-Tubes

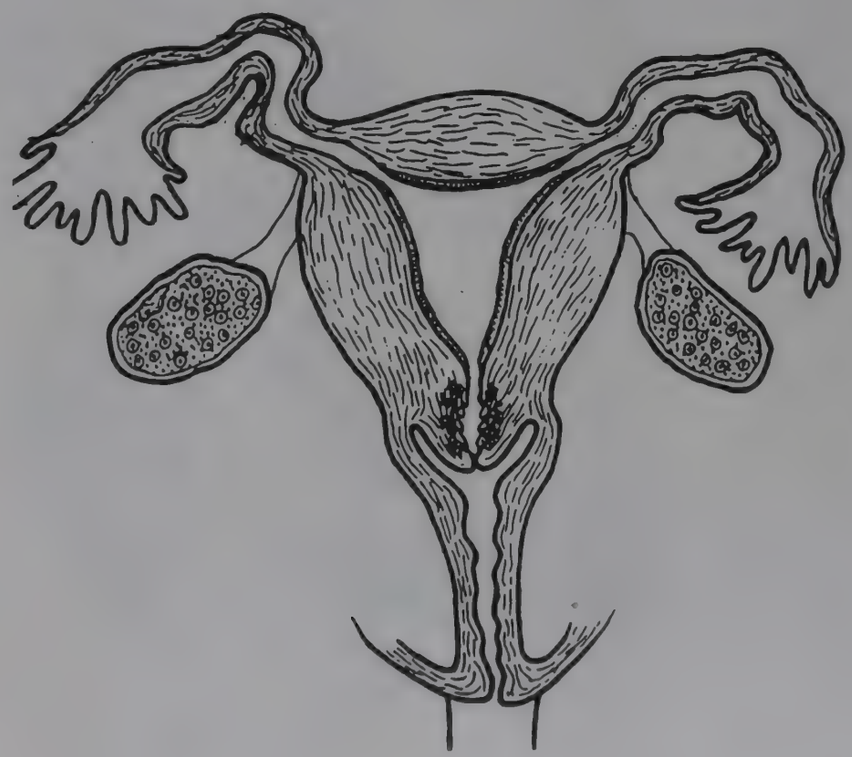
The egg-tubes are soft thin muscular tubes, a little longer than one's middle finger. From the top of the womb on either side, they stretch outward and backward. They contract and relax with rolling wave-like motion.

The egg-tubes have two functions:

to transport the egg to the womb, and
to let sperms travel to meet the egg.

Unlike sperms, eggs can not move by themselves. They are helped in two ways:

- tiny hair-like *cilia* lining the egg-tubes sweep the egg forward, and
- muscle contractions push the egg through the egg-tube.



The Womb

The *womb*, is the organ which doctors call the *uterus*. The womb is mostly made up of muscle, and is shaped like a pear, or a longish guava. It is about the size of one's own fist. It sits within the hollow of our pelvic bone, supported by pelvic muscles and tendons, and covered by a broad sheet-like membrane attached to the side-walls. The bladder is just in front, and the end of the large intestine (rectum) passes behind. From the upper corners of the womb, the ovaries and egg-tubes stretch backward. The inner lining of the womb is called the endometrium.

The womb has three parts:

- the upper part forming an umbrella-like *roof*;
- the *main* part, with a flat empty triangular space in the middle;
- the narrow lower part, called the ***cervix***,.

The womb is usually somewhat bent on itself, and curved forward over the bladder. In some women, however, the womb naturally curves backwards, or is not curved at all. If one examines the womb by hand (as we will later do a 'bi-manual exam'), it feels firm and is about the size of one's own fist.

The Cervix: This lower part of the womb is very important, especially because of its role near ovulation. Through it runs a canal. Its' opening is the *mouth* of the womb, and pokes into the vagina. It produces a special *mucus* secretion.

Inside the canal of the cervix are a lot of little tree-like sacs or *crypts*. These crypts secrete a special mucus regulated by estrogen and progestrone. *Estrogen* makes the mucus slippery and mildly alkaline, while *Progestrone* makes the mucus thick.

The cervix is also important in child-birth. If you have never given birth to a child, the opening in your cervix will look like just a dimple. But if you have given birth, the cervical opening will look and feel irregular and wide. Also, you may have relaxed support of the uterus making it difficult to feel the rising and lowering of the cervix as a fertility sign. The cervix and its secretions also slow down infections from getting into the womb.

The Vagina

The vagina is a strong, wavy muscular canal that leads from the womb to the outside. The cervix dips into its' upper end. There is a mote-like circular space in the vagina all around the cervix, which is deeper behind and shallower in front.

The vaginal membrane is usually quite tough and the lining is *not* very sensitive. But, its opening is surrounded by the *clitoral sponge and muscles*, so it becomes actively involved in sexual sensations and orgasm.

The vaginal has three important functions:

it lets menstrual and other secretions out,
it lets semen be put near the womb, and
it gives passage to a baby at birth.

The Ecology of the Vagina: Just as forests and grasslands change their colours and smells with the seasons, likewise the insides of our bodies constantly undergo cyclical changes. Our genital parts also change regularly with a seasonal rhythm. There are lots of tiny 'bacteria' and other little microbes (one-celled micro-animals and micro-plants) that live harmlessly inside us. They are happy with our normal odours and secretions. One can find microbes living on our skin, in our mouth, in our breath passages, in our intestines and in our vaginal passage. Not only are most of these little beasties harmless, but they help protect us from other harmful microbes which might enter or over-grow in our body and which could make us quite sick.

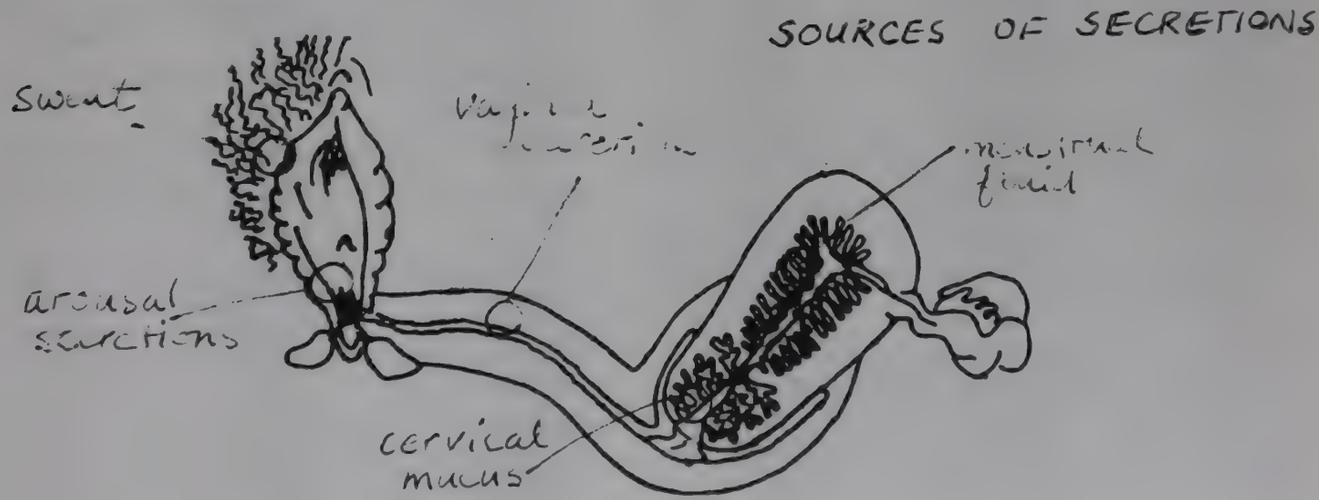
We speak of nature as having a ***balance***. At any given time and from season to season, life in a forest has it's own natural order. The vagina also has an intricate internal order, or *'ecology'*.

The vaginal environment is normally somewhat acidic because of the healthy secretions from the cells of the vaginal walls. This discourages harmful microbes. Harmless microbes like ***lacto-bacteria*** prefer this acidic environment, and even help to keep it acidic. As ovulation time approaches, the fertile mucus secretion flowing out of the cervix makes the environment turn slightly ***alkaline***. When the mucus becomes thick and infertile, the vagina again becomes ***acidic***. The menstrual flow, mixed with mucus, is once again somewhat alkaline. Thus, the ecology changes during the phases of the menstrual cycle.

Some kinds of food change the vaginal environment. Women have a sense of these kinds of effects when they speak knowingly of *'hot'* and *'cold'* foods.

The vaginal ecology can be changed by several ***upsetting factors***, like men's *'jabardasti'* (force), poor nutrition, disorders like anaemia, diabetes, tuberculosis and sexually transmitted infections. Certain conditions of life like pregnancy and menopause bring with them changes in ecology. Certain medicines like *anti-biotics* and hormones (including *contra-ceptives*) tend to upset the balance. Too much physical or emotional ***stress*** may further lower our resistance to disorder. The natural flow of secretions from the vagina keeps the vaginal environment clean and fresh.

In fact, all of our body's *secretions* have their own importance in maintaining our whole internal ecology. As thick forests have moist air and earth, so do we have moisture.



Isn't it interesting that women's secretions are seen as 'dirty', but men's secretions are taken as symbols of masculinity!

Experiences of First Menstruation, and After

Sexuality begins to bloom with the start of ovulation and menstrual cycles. At this positive time in a girl's life, she gets cloaked with the myth of untouchability that links menstruation with pollution and shame.

- *It was dark. I felt myself wet and sticky, and I was worried. In the dim light I saw dark patches on my skirt. When I touched inside my fingers got covered with blood. I started crying. My mother woke up and told me that I have grown up now. She gave me a bath in the morning and made me sit outside the house for eight days. I had a special plate and tumbler. New clothes were given to me.*

- *After I was married I was asked to sit outside for five days. Periods were seen as dirty. I could not keep my menstrual cloth inside the house. I had to leave them outside. It was difficult drying them in the sun - the dogs used to take them and run away. My in-laws told me that the rags are dirty and smelly. I had lots of problems washing the rags clean, because there was no soap.*

- *I was married before my periods and allowed to stay at my mother's place. One day I went to harvest groundnuts. While working, I found my skirt wet and sticky. There were red patches on it. Men were working at the other side of the field. I tried to pull the skirt between my legs and go home. The other women noticed and told my mother.*

- *There was rejoicing, because now they could send me to my husband's house. I didn't know what was happening. They bathed me and gave me coconut and jaggery to eat. My husband was informed that I had grown up. He brought me a saree and blouse, flowers, kumkum and coconut. I was made to sit outside the house on a new mat. All the women sat around me singing and dancing. I wasn't allowed to work - just had to sit dressed up, admire myself in the mirror, powder myself, apply kumkum.*

Next period they didn't give anything. I was disappointed. They sent me to my husband's house to my in-laws. There I couldn't touch anything before I had a bath. Now whenever I have my period I am made to sit outside.

I got married at the age of five. My husband died two years later. I got my periods when I was twelve, at my in-law's place. I faced lots of suffering. I got pain and heavy bleeding. My in-laws treated me badly. I was not allowed to touch anything. I had no celebration like other young girls. I missed my mother who died when I was very young. My in-laws use to have nice food inside but they use to make me sit outside and give me only ambil (fermented cereal) to eat, or starve me. My father-in-law use to make me sit all night and not allow me to sleep.

- *In my community, it is forbidden to sleep on a bed during our periods - we must sleep on the floor. At this time we do not wear red sindur, We have to wear black sindur and all these signs mark us as widows. We can't participate in religious ceremonies since we are impure. I wanted to attend a pilgrimage with my family, so I took hormone pills to postpone my periods.*

- *Only for the first menstruation do they celebrate our fertility with a grand feast. After that, they treat us as untouchables - as dogs. Nobody cares. We have to sit outside as we are dirty. We can't touch anything. Even our shadow should not fall on the images of gods that are around the house.*

In Andhra Pradesh, when a girl gets her first period, her family organises a ceremony, a rite of passage into adult-hood. This is the occasion to instruct her on the code of conduct, and from then on she must be quiet and withdrawn. Often her schooling ends, and now she is stopped from playing with boys. Certain restrictions are lessening, but the ideology that woman is impure and her body is shameful still persists.

Were there any positive feelings as the participants passed from girlhood to womanhood?

We were happy we would be going to our husband's place.

Our dreams to get married would now be fulfilled.

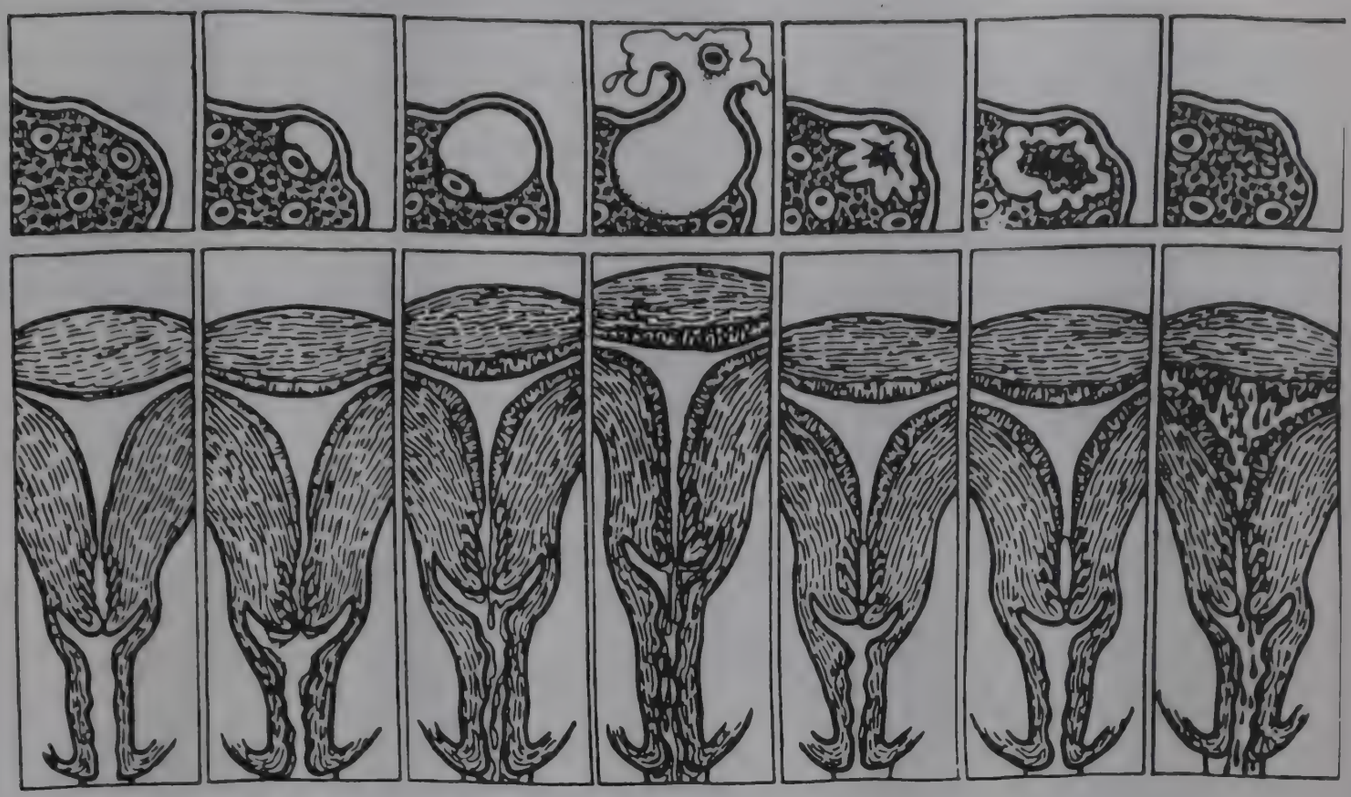
We had aspirations to be like actresses in the cinema.

We were happy for the attention and the new clothes.

We were attracted towards others and needed physical contact.

We were curious to explore our body.

Indeed, menstruation taboos are based not on facts but on fears. Women's blood magical - nobody knows where it comes from. Yet, all know it is related to a woman's physical ability to bear and give birth, an ability which men lack...



Ovulation and Menstruation

While women suffer so much on account of menstruation taboos, the fact that they produce an egg and how this relates to their periods is hidden from them.

The cyclical changes happen at various levels at the same time.

Each egg-producing cycle begins with menstruation, as several eggs begin to mature in the ovaries and estrogen is secreted. One of the follicles grows bigger and the other die back.

Estrogen makes the womb lining develop, and makes the cervix to secrete fertile mucus. When the egg is ripe, and estrogen reaches a peak level, this stops the pituitary from secreting FSH - it starts secreting LH, causing the ovary to release the egg (***ovulation***). The left-over empty follicle comes together into a little mass, the yellow body to secrete progestrone and still some estrogen.

Progestrone makes the womb lining thicker, and calms the womb muscle. It causes thick cervical mucus to plug the cervix. If the egg is not fertilised and implanted, in about ten days the yellow body stops working - the hormones stop, the plug of mucus dissolves and the cervix opens. Because progestrone no longer calms the womb its muscles start contracting. This interrupts the blood supply to the lining, which breaks up, separates and comes out as 'menstrual blood'.

The low levels of hormones cause the hypothalamus and pituitary to start acting again, secreting FSH to act on the ovaries. So, the next egg-producing cycle starts up, and so on.

⇒ An egg is released only once in a menstrual cycle, and hence a woman's fertility is cyclical.

⇒ Fertility cycles vary from woman to woman, and from one cycle to another cycle in the same woman.

We've Broken the Do's and Don'ts...

This whole packed six-day session dispelled a lot of fear and anxiety. The women learned that menstrual periods are not caused by anything mysterious, and that it is not polluting or dirty. They also came to feel their bodies are beautiful, and not shameful. All gave a big sigh that, at last, we had broken a lot of dos and don'ts, and we could now look at ourselves.

The women were also thrilled about the new knowledge of the 'santosham button', and they wanted to share it back home with others! We thought that this might get them into trouble, so we cautioned them,

Just now, be selective about sharing your experience. Don't share this outside our group. We are going through a process together. In this course, there is still a lot to be learned, and much to think over. Be sure to share only gradually and selectively.

But some did share with their partners and other women at the project and in the sanghas.

Fertility Awareness and Sexuality

Objectives

- to expose and over-turn 'myths' relating to fertility and sexuality
- to understand the link between fertility and sexuality
- to learn 'fertility awareness' for gaining control over our fertility and our sexual life
- to see how man-woman power relations affect fertility and sexuality
- to define sexuality beyond 'sex'
- to learn about safe birth control methods

Methodology

Sharing:	experiences of social myths, power relations between the sexes
Charts and Pictures:	sexual/reproductive parts (review) tele-system (review) ovulation and menstruation, fertilisation and implantation the menstrual cycle signs of fertility fertile and infertile phases safe birth control methods
Booklet:	mucus observation guide
Exercises:	touching and feeling different mucus-like substances making FA observation chart & using symbols analysing patterns of fertility and infertility exploring double standards for the sexes; identifying gender stereo-types

A Sense of Balance...

As health workers in rural areas, some of us have noticed a sense of reproductive balance which seems to be part of women's living. Several of our participants were widowed early without children. Yet, still, they were part of a community of women who recognise body rhythms and seasons as part of daily experience, not separate from the rest of nature. So, learning 'fertility awareness' as a skill was interesting and fascinating, and most of our participants were quick to grasp it. In fact, the sangha women who had never had formal schooling took to it quite naturally and enthusiastically, even to details of hormone actions and effects.

Women are used to natural cycles of fertility and infertility, even if they find much a mystery. They realise that certain actions and traditions affect their reproductive rhythms. Prolonged breast-feeding, of course, is one. When we asked them whether feeding a child one's milk beyond two years doesn't sap their strength, they replied,

If I stop breast-feeding my child, another one will come soon. My blood and bones will become even thinner. And, all my children have been born three years apart. Even my mother and her mother followed this pattern.

Custom modifies sexual relations and fertility, too. After child-birth, women may be allowed to stay for months at their mother's place. During certain months and festivals, refraining from sexual relations is part of the rites.

In some places men migrate away to work.

My husband is away as a seasonal labourer - he comes home once in three or four months. In this way, my children have got spaced apart.

But, then again, many women have got caught when they couldn't afford it.

I was always worried I would get pregnant.

Changes in modern life and the economic trends have disturbed the cultural supports and brought in hazardous factors. In urban areas, replacing breast-milk with bottle-feeding is a well-known calamity.

Whatever has been women's reproductive experience - of sustainability or accident - they have never fit the population controller's description of senseless, mindless multiplying animals.

What is Fertility Awareness?

Technically, fertility awareness means a woman's ability to monitor her *fertility from day to day* by observing various changing body signs during the phases of her menstrual cycle. The changes are related to the process of egg-ripening and release, which we call *ovulation*. It does *not* depend on calendar rhythm estimates.

Fertility awareness can help women (and couples) in achieving or avoiding pregnancy. Also, it helps women to predict the date of next menstruation, to detect pregnancy early, and to help detect and track certain health disorders. It can be an important aid to use barrier methods of contraception skill-fully.

Fertility and sexuality are closely linked. Just as fertility ebbs and flows like the sea, so also we can feel waves and rhythms in our experience of sexuality.

Some Myths

Abuse and violence against women is supported on a base of ignorance maintained by myths wide-spread and deeply rooted in society. Many myths are linked with fertility and sexuality. Society uses them to mould our behaviour and control us. When we began to talk about myths in our group, many examples flowed out -

menstrual blood is dirty and polluting

when a girl's periods start, education should stop

if a girl is not controlled and married off early, she brings shame to her family and her community

women's sexuality is dangerous to society

bad women lead good men astray

a woman is a virgin if her hymen is untorn

just after her period a woman is most fertile

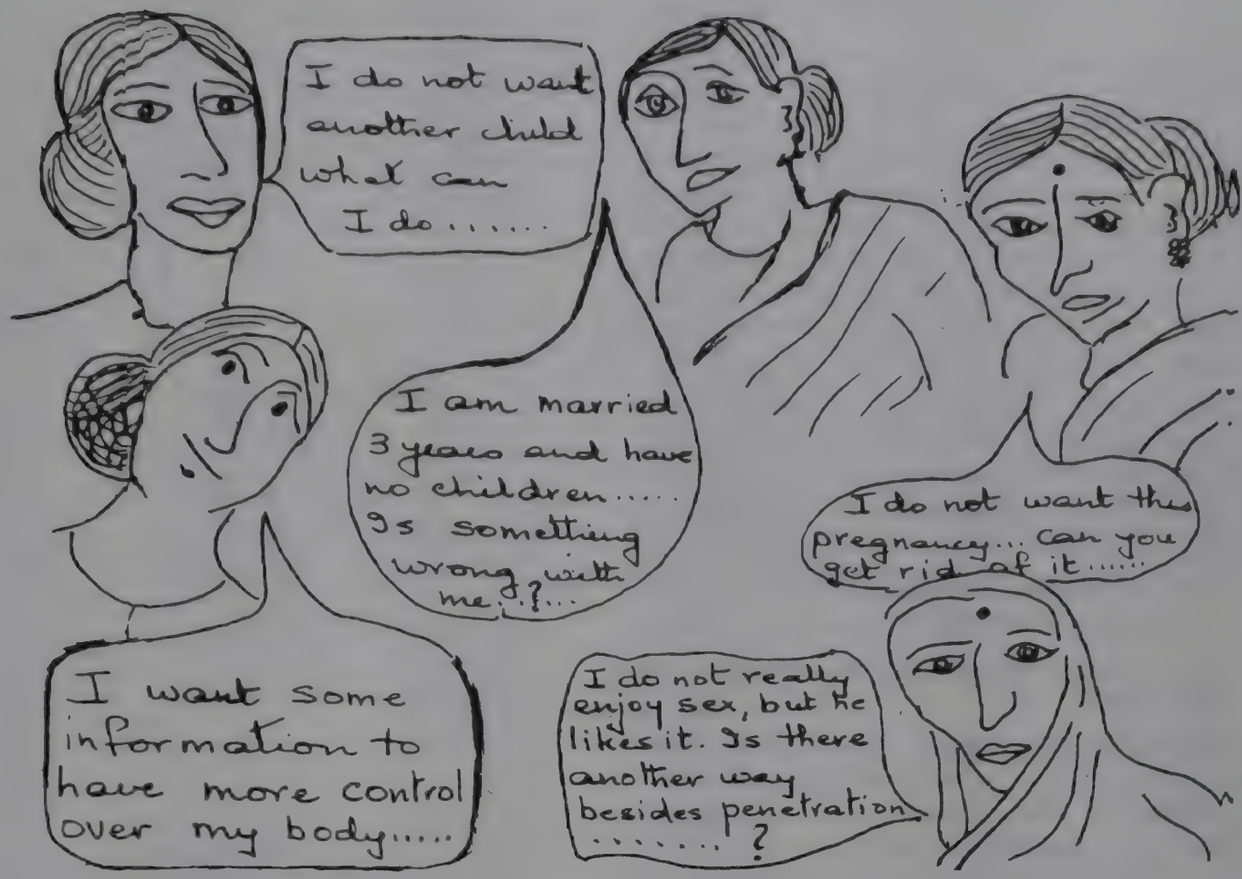
a woman's periods should come every twenty eight days

a woman is like a field for a man to plant his seed

men are naturally sexual and can't help it

it's a woman's fault if she has only girls

and so on, and so on... To break down myths, we give importance to our *experience*, and we expand our experience by gaining *new information* and *skills*.



Developing Fertility Awareness Skills

Learning *fertility* awareness is one way to take back control over our bodies. It includes reaching a full awareness of our sexuality, within our real-life contexts. Basically, fertility awareness involves experiencing and understanding the biological patterns of change. From this, one can interpret the phases of fertility and infertility during one's menstrual cycles.

Fertility and sexuality are not only *biological*. Fertility awareness takes into account the experience of fertility and sexuality as moulded by society, too. It leads to a change in perception about women, countering the myths which distort men's and women's behaviour with each other. No longer can a woman be thought impure during menstruation and childbirth, and her powers of fertility and reproduction degraded.

Fertility awareness is a kind of *body literacy*. It enables us

- to free ourselves from baseless superstitions
- to understand emotional changes better
- to recognise ovulation and predict our periods
- to time pregnancy and child-birth
- to help know why some of us don't conceive
- to avoid the use of harmful contraception
- to arrange for a safe abortion early, if needed
- to detect unhealthy changes early
- to avoid unneeded medical interventions
- to demand responsibility from our partner and possibly to deepen our relationship.

You can develop your sensitivity to the natural rhythms and understand what your body says to you - if only you take care to 'listen' with all your senses.

The Body's Signs of Fertility

Many things go on *at the same time* during a woman's menstrual cycle. Aside from changes in the ovary which happen before, during and after ovulation, there are other changes at the level of hormones in the blood-stream, in the lining of womb, in the cervix and the cervical mucus, in the vulva, in the breasts and in the rest of the body. The temperature of our body even rises slightly. The body signs reflect the hormonal changes. Let us look at each sign.

⇒ ***The Cervical Mucus:*** Mucus produced by the tiny sacs within the cervix develops 'fertile' qualities because of estrogen, while the egg ripens in the ovary. Fertile mucus is favourable to sperms and infertile mucus is hostile to them.

- *Infertile mucus* is thick, pasty, sticky, gummy and opaque (not transparent).
- *Fertile mucus* is thin, slippery, stretchy, and transparent.

⇒ ***Changes in the Cervix:*** Touching the cervix with a finger, many women find the cervix firm, closed and low down during the infertile phases, and *soft, open and lifted up* during the most fertile time. During the menstrual flow, the cervix opens enough to let out menstrual secretions.

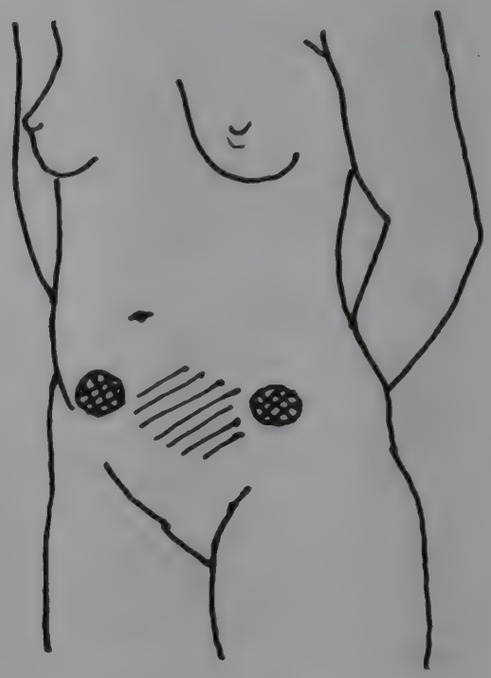
The changes in the mucus and the cervix, caused by estrogen hormone in our blood, cannot tell us the exact day ovulation takes place, but it tells us when the *egg is getting ripe* and preparing to leave the ovary.

⇒ ***Rise in Temperature***: Our body temperature rises slightly when the egg is being released because of the change over from estrogen to progestrone.

Other Body Changes: Around the time of ovulation, other signs provide *additional* information about our fertility pattern. Since all of us don't experience them, they are not as dependable for knowing the fertile and infertile times.

As ovulation approaches, our ***skin*** glands secrete less oil. Some women find that their bodies hold more *water*, which makes them feel slightly bloated; that they have an increase in ***energy***, and even a sharper sense of vision, smell and taste, along with the heightening of sexual *desire*.

⇒ ***Mid-Cycle Pain:*** Low down in the belly, we may experience mild pain around or at the time of ovulation. This pain is of two types for two different reasons.



- one may feel *dull cramping* pain low down in the middle starting *before* ovulation, coming in waves something like menstrual cramps. It is because, as ovulation approaches, estrogen stimulates one's womb muscles.
- A *sharp prickling* pain may be felt over the left or right ovary *at ovulation* itself, as some fluid bursts out with the tiny egg. The pain may last from a few seconds or minutes up to an hour or even more.

⇒ *Breast Changes:* Changes in breast sensation may be variable in different women, and again it may be of two kinds.

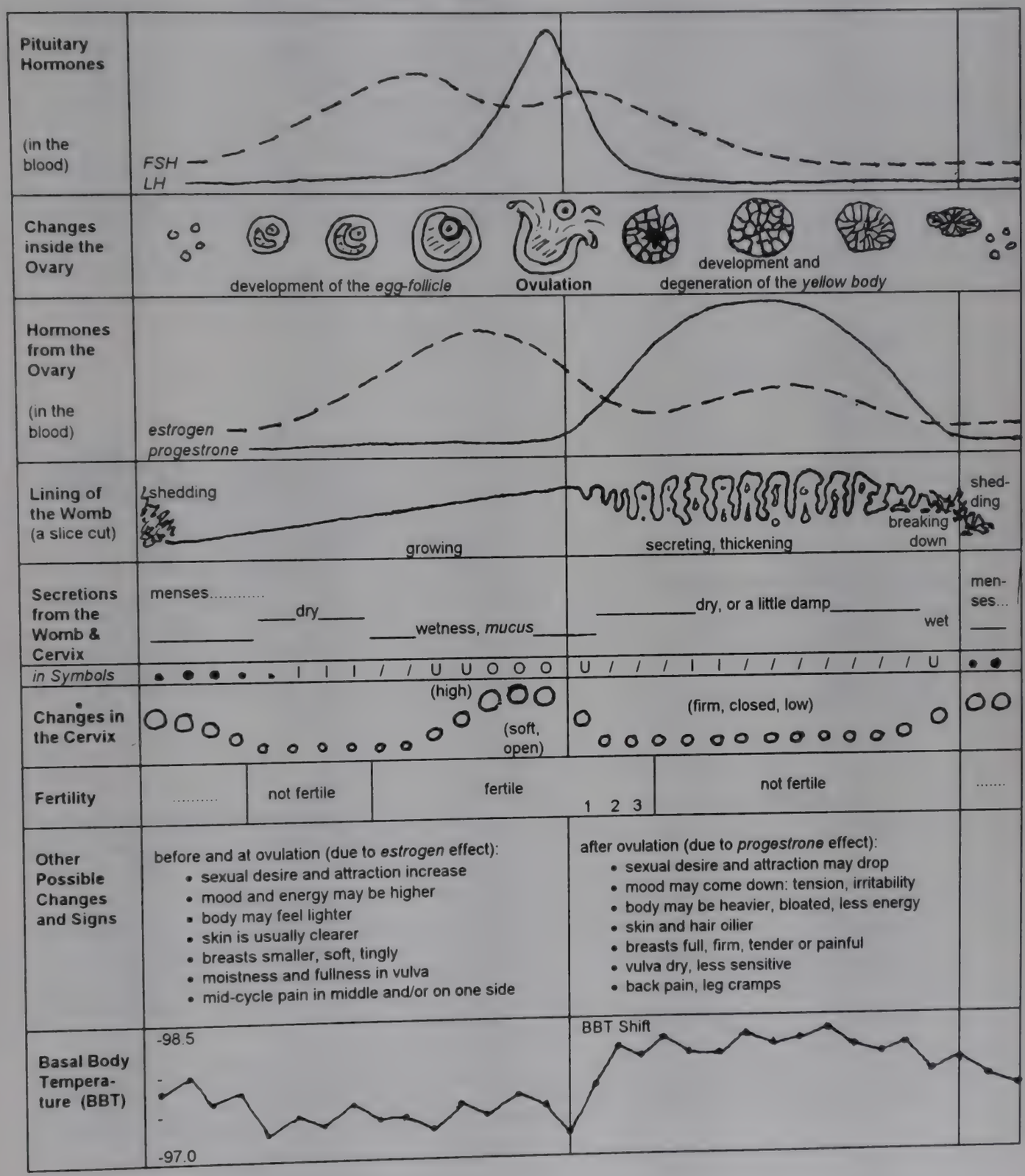
- one may feel tingling *without heaviness* during the fertile phase.
- one may feel tenderness or pain *with heaviness* after ovulation, because of progestrone.

⇒ *Changes in Mood and Desire:*

- one may feel more energetic, and the mood may be higher *as ovulation approaches*; sexual desire increases.
- sexual desire may drop, and energy may *lower* after ovulation; in the ten days *before the period*, one may feel tense and irritated.

Menstrual Cycle Events Related to Signs and Phases of Fertility and Infertility:

This chart shows the changes in hormone levels and other related changes in a woman's body during a menstrual cycle. During the first part of the cycle, up to ovulation, the effect of *estrogen* is noticed, while after ovulation, *progestrone* dominates. The experience of these effects is different for each woman, and not all women will feel all these changes. Also, menstrual cycles may show a lot of variation from cycle to cycle and among different women.



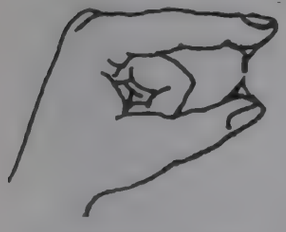
Observing and Charting Whole Cycles

Observe several times in the day and last thing at night. Record your observations - whatever you actually see - in a fertility awareness chart, using symbols. Describing with simple words is a good idea, too. Give importance to your sensations.

Observing the Cervical Mucus: Look for dryness or wetness, amount, colour, texture, slippery-ness and stretchy-ness. Test the vaginal secretion and mucus between your finger and thumb.

- dry (no mucus) ,
  nothing comes on the fingers

- non-stretchy, crumbly or like cream
  on the fingers (not fertile)



- stretches a little but breaks
  (slightly fertile) -

wet, very stretchy, slippery
(extremely fertile).

To practice *feeling and observing*, we did an exercise with different common substances - *chunam*-water, *curds*, milk-cream, rice paste, liquid gum and raw egg-white - to simulate possible types of mucus and non-mucus secretions.

⇒ ***Observing Changes in the Cervix:*** Do this during your bath, *after cleaning you hands* with soap. In a squatting position, insert one or two fingers into your vagina up to the cervix.

- During natural days of infertility, the cervix may be lower, nearer the vaginal opening and easier to touch. It feels firm, like the tip of your nose, and it is closed.
- As fertility increases, the cervix may get higher and it is harder to feel it, and soft, like your lower lip, and it opens so your finger can poke in.
- When fertility ends *after ovulation*, the cervix lowers and is again easier to reach, firm and closed again.
  again.

⇒ ***Observing Other Signs:*** Make a note of any other signs which you feel may be linked to your cycle, particularly ***mid-cycle pain, breast sensations*** and ***mood changes***.

If you are taking any ***medicines***, or if there is any emotional ***stress*** (at home or work-place) or ***illness*** (like fever) make a note of it so that you may co-relate it with the changes in your whole chart later.

If you are using your observations to practice birth control, either naturally or by a barrier method, or if you want to get pregnant, you may want to mark the days when you have ***intercourse*** - with or without a condom or diaphragm.

Using Symbols and Charting

We didn't begin with a ready-made chart, but worked out the design ourselves to be used with symbols. The chart we designed worked out to be a whole year's calendar in two sheets, with six months on each. Keeping in mind the sangha members and using the chart at village level, there was a detailed discussion about including the phases of the moon, the weekly market days, and also calendar dates. To our surprise, even the sangha members, who were in the process of learning to read and write, preferred using calendar date numbers. All the same, the charts made provision for phases of the moon and market days, plus festivals, thus giving a wider reference for women back home.

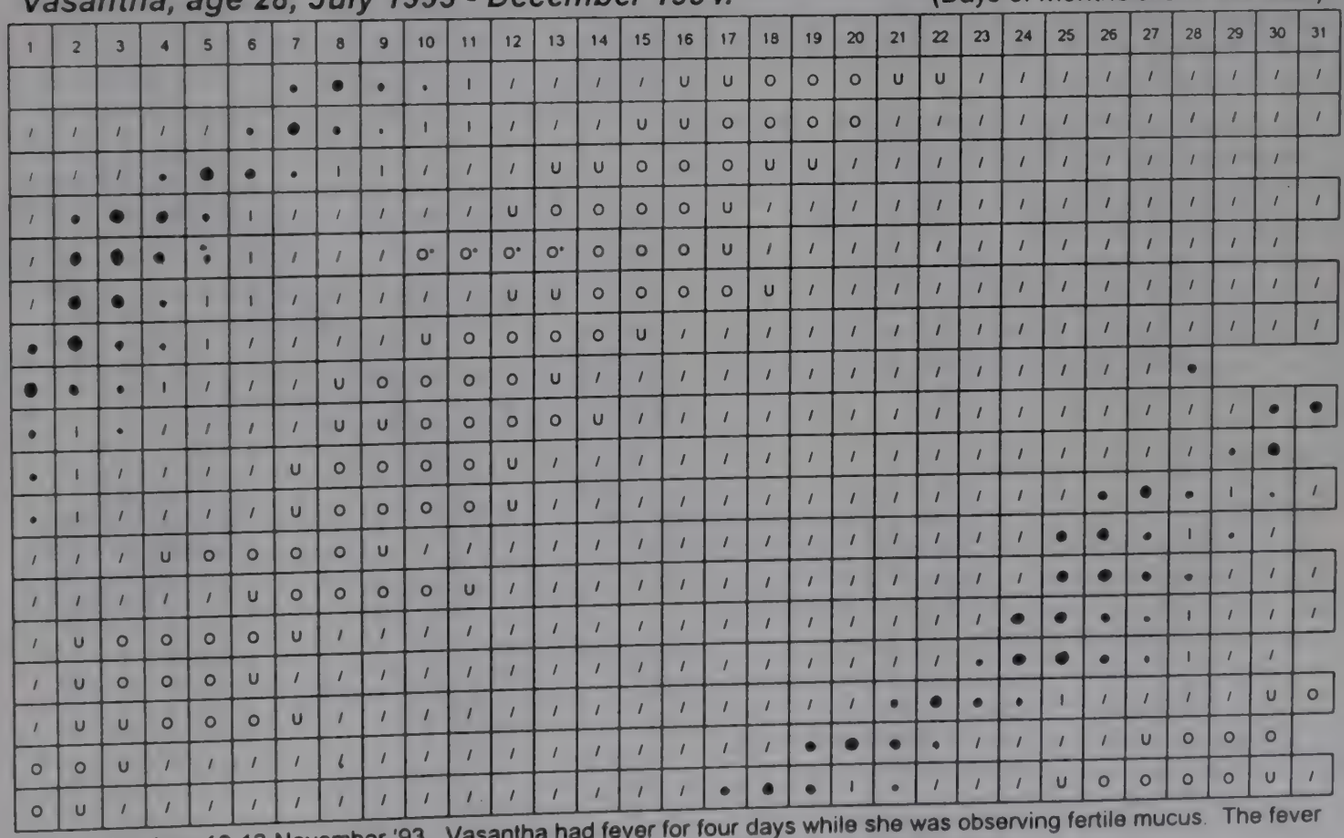
The basic *symbols* are

dryness, no secretion	I
pasty secretion, tacky mucus	/
stretchy mucus which breaks	U
wet, stretchy, slippery mucus	O
blood spotting	•
bleeding	●

After finalising the design of the chart, we xeroxed it. Each woman attached her two chart sheets onto the back and front of a piece of *cardboard*, so that it would last longer.

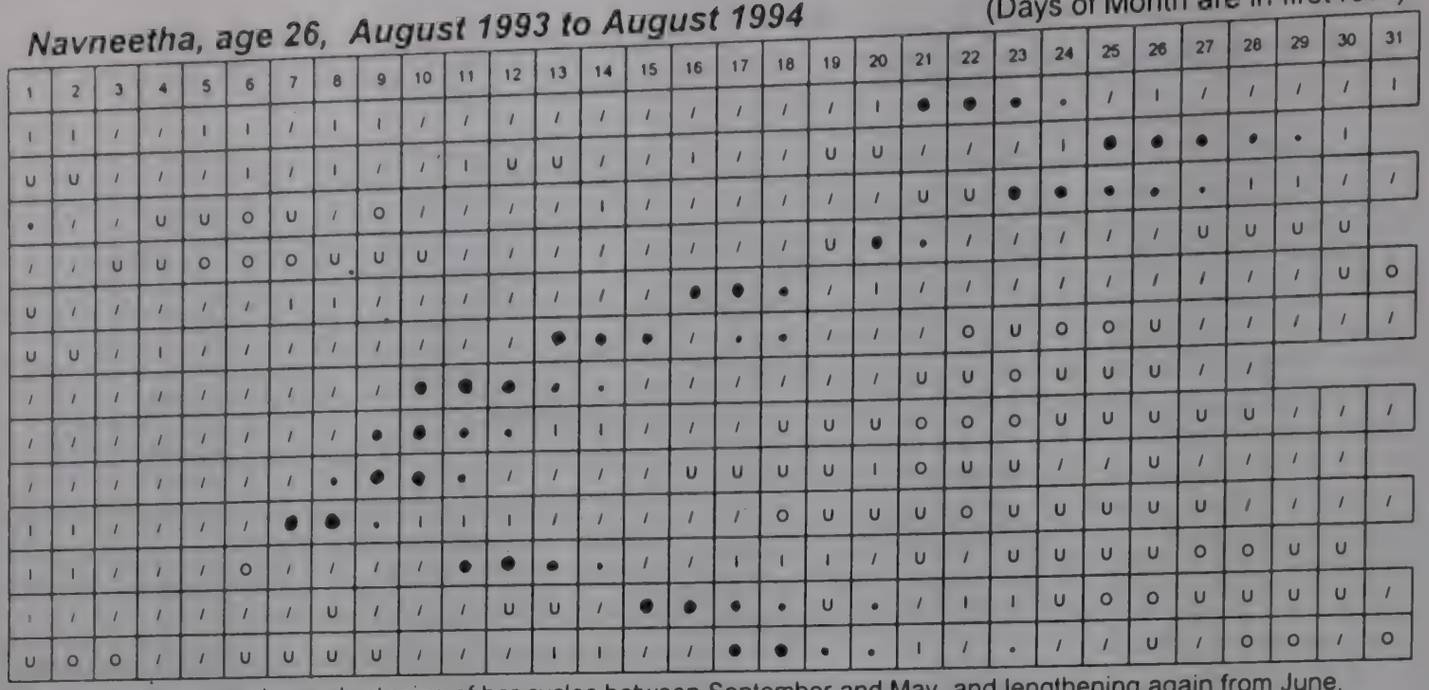
Here are two examples of charts from our group

Vasantha, age 28, July 1993 - December 1994. (Days of Months are in first row.)



Notice the days 10-13 November '93. Vasantha had fever for four days while she was observing fertile mucus. The fever appears to have postponed ovulation, and prolonged the days of fertile mucus in that month.

Navneetha, age 26, August 1993 to August 1994 (Days of Month are in first row.)



Navneetha's pattern shows shortening of her cycles between September and May, and lengthening again from June.

Eggs and Sperms

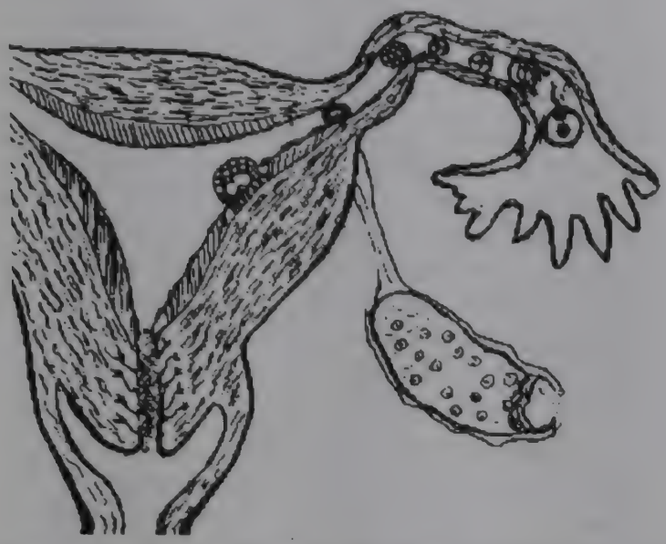
A woman produces only one ***egg*** per month (or rarely two, which can result in twins) for about thirty-five years - at most, a total of about four hundred in her life. The egg is quite a lot larger than a sperm - about the size of the head of a pin. After it bursts out of the ovary, an egg lives about *twelve to twenty-four hours*.

A man usually produces about seventy million (seven crores) ***sperms*** every day. Each sperm is about the size of a pin-point. The tiny sperms dart about by lashing their tails from side to side.

In fertile mucus, which is mildly alkaline, sperms can live for as long as *three to five days*. But, if thick infertile mucus blocks the canal to the womb, the sperms die soon in the vagina from the normal acidic secretion.

How We Get Pregnant

Fertilisation: When the ripe egg bursts out of the ovary, it is picked up by the nearby finger-like ends of the egg-tube, and it begins travelling towards the womb. Union of egg and sperm always occurs in the first part of the tube within twenty four hours of ovulation when the fertile mucus flows from the cervix. Through the slippery mucus, the sperms swim easily through the cervical canal, making their way up the womb to reach the egg-tubes. Only a few hundred reach the right egg-tube, but quite a few may reach the egg. After one sperm breaks through, the egg wall tightens to preventing another from getting in.



Implantation: Within a day after fertilisation, the egg-cell begins to divide - first into two cells, then into four, then eight, sixteen and so on. After about four days, when the fertilised egg-cell mass reaches the womb, it has several hundred cells with a little fluid space inside it. It implants itself firmly by *around the seventh day after ovulation*, sinking root-like projections deep into the soft womb lining. The embryo begins to send *biochemical messages* through the blood to inform the yellow body to continue secreting progestrone hormone to support the pregnancy, until the *placenta* can take over.

Learning fertility awareness can help women who want to have children and those who have problems getting pregnant. A couple can time sexual intercourse with ovulation. To maximise the chances of pregnancy,

⇒ the couple should have intercourse on *alternate days* during the fertile phase, letting the man's sperms build up in between.

Charting one's fertility and infertility patterns can sometimes help to find a cause of childlessness without medical or surgical intervention. A man's sperm count may be low, and simple timing might solve the problem.

Nageshwari is now working with twenty childless couples. She has explained fertility to them, and has taught them how to chart the patterns of mucus and other signs. Side by side she has examined for any physical problem or infection. She has sent them for simple tests like sperm count and VDRL. After a few more months she will be able to analyse their fertility and infertility patterns with them. Then, she will know whether there is need to refer for further tests or treatment.

Situations of Varying Fertility and Infertility

At certain times in a woman's life her fertility cycles may be interrupted by natural or unnatural events and factors.

After Child-birth, while Breast-feeding: During the months of pregnancy, high levels of both estrogen and progesterone in a woman's bloodstream hold back her pituitary gland from sending out FSH to stimulate her ovaries. Otherwise, the fertility cycles would continue, with ovulation and menstruation and so on.

After she has given birth to her child, a woman's interval of *natural infertility* continues for some time because of a pituitary hormone - prolactin. This happens in the following way:

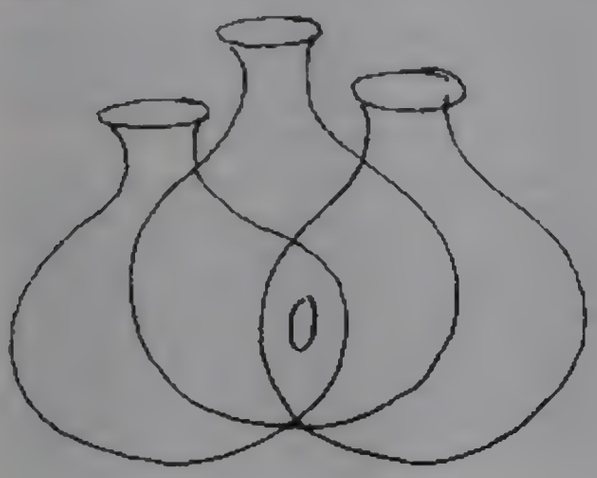
The baby's sucking at the nipple sends tingling messages from the breast via the nerves and brain to the pituitary gland, which secretes *prolactin* into the blood. Prolactin prods the breasts to make more milk, and also directly keeps the ovaries inactive. Because there is no ovulation, periods don't start either. This infertility protects both the woman and child from another pregnancy too soon.

Natural infertility usually goes on for a few months or even longer, depending on *how long and how often a woman breast-feeds* her child. Through frequent and total breast-feeding, a woman can prolong it.

A breast-feeding woman should not wait for periods to tell her that she can conceive. Since she will ovulate two weeks *before*, she can conceive without even getting a menstrual period! She should be alert for her body's fertility signals to begin.

Before fertility settles down into regular motion again, there may be several 'patches' of mucus days, interrupted by infertile 'dry days'. This may continue for weeks or months. So, remaining alert means having both skill and patience.

It is best if a woman learns fertility awareness *before* her first pregnancy, so that she can now 'listen' when her body says she is becoming fertile again.



Before, During and After Menopause: Menstrual cycles tend to get shorter as one gets older, but they get longer for some. Eventually, around life's fifth decade, a woman's ovaries start running out of eggs. The pituitary gland secretes more FSH, but in vain, as after a time egg-follicles no longer grow. Because of high FSH and infrequent ovulation, it is a period of fluctuating and high *estrogen* in the bloodstream.

A woman's fertility chart would now show irregular long patches of 'fertile-*type*' mucus, an occasional ovulation and menstrual period, or possibly extra bleeding maybe along with fibroids that act up. The high estrogen bouts may cause body discomfort, including sudden 'hot flashes' and sweats. After menopause, the cervix no longer secretes fertile mucus, and the lining of womb and vagina becomes thinner and dryer.

After Hormonal Contra-ceptives: These artificial methods of birth control over-ride one's natural hormonal balance and ovular pattern. When a woman discontinues pills it may take a while for her natural fertility to reassert itself and for a regular pattern of signs to be re-established. If she has used injectible contra-ceptives or a hormonal implant, the time taken for the effect to wear off may be longer.

If a woman keeps a chart, she may have to wait while seeing mucus patches without ovulation for a long time. In prolonged use of hormonal contraceptives, there is a risk of fertility not returning after stopping the method.

Natural Irregular or Long Cycles: Some of us just ovulate less often, so our cycles are long and *appear* irregular.

During Times of Emotional and Physical Stress: Any kind of stress may affect our fertility patterns, leading to delay in the mucus sequence. It may be suppressed entirely or it may be interrupted.

During times of ***starvation*** or ***mass migration*** of refugees, it is well known that women's fertility declines. This has served as a protection for women who could otherwise not bear the extra stress of pregnancy.

Also, ***women athletes*** ovulate less often, and some may find their periods stop. It may be due to the physical stress of athletic competition, but also it is related to their lack of body fat, required for making the estrogen and progesterone.

Illness, chronic or otherwise, does not necessarily reduce fertility. In certain disorders, like Tuberculosis, it is important that a woman be able to protect herself from getting pregnant until she heals completely.

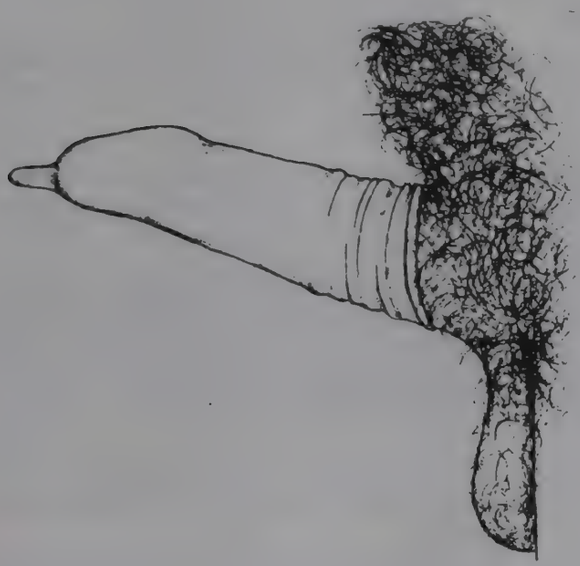
How Can We Avoid Getting Pregnant?

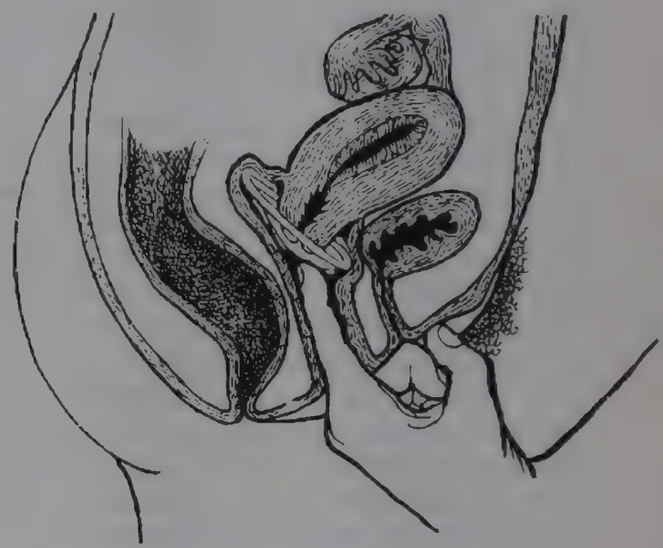
When fertility awareness is used as a *basis for birth control*, it may be called 'fertility awareness method' (FAM). The basic 'rule' is

⇒ ***On fertile days, postpone any sexual activity by which sperms and egg can meet.***

All the fertility signs are important, not only the mucus. If ever you have a *doubt* about the signs, or you couldn't observe on a certain day, it's best to take precautions as if you were *fertile*.

Early Infertile Days	intercourse without condom is OK, after observing dryness throughout the day to know that you are not fertile
Fertile Days	have non-penetrative sex or use a condom when mucus or wetness starts, until three days after the last day of fertile mucus; also, watch for other signs of ovulation
Late Infertile Days	intercourse without condom is OK as long as there is dryness or daily unchanging infertile secretions





Barrier Methods of Birth Control

If you don't want to get pregnant during the fertile time, you can use methods that block sperms from meeting the ovum. These are called 'barrier methods'

The ***condom*** is worn over the erect penis and prevents semen from getting into the vagina during intercourse. Used properly, it is effective as a birth control method. During the fertile days, the condom may be used with a *spermicide*. A condom should be used only once.

To protect herself from STIs, a woman can ask her partner to use a condom even during the infertile days.

The ***diaphragm*** is a cup-like barrier device for women to use. It fits in one's vagina, covering the cervix and rests just above the pubic bone. It blocks the entry of sperms into the womb. One can use a *spermicide preparation* along with a diaphragm, but it may not be necessary. It has to be left in for six hours after intercourse. If cleaned and cared for, it can be re-used even for years.

Sometimes, for some reason, a woman may find herself with an unwanted pregnancy and need to have it aborted. Then, ***safe* abortion** services are a necessary back-up

Sexual Relations and Fertility

The experience of sexuality is inter-woven with fertility. Yet, women are seen as fertile but asexual. Sexual relationships inevitably force women to face the possibility of getting pregnant. Society narrowly defines sex as penetration of vagina by penis. Some of us find this kind of sex oppressive and traumatic. Often women feel that they are being treated as mindless objects used to satisfy their partner's sexual urges. Sometimes they even experience the sex act as rape.

Sexuality is a difficult area of women's lives. Getting in touch with it was an important part of self-help. But it wasn't easy - it involved gut-level effort! And, to share the experience with others, even more so. But, we realised how important it was, otherwise we would remain cut off from other women's experiences. Self-help training is a space for women to get in touch with sexuality, and to break the culture of silence.

Almost half of our group were married, while the rest of us were single women. A woman has a right to sex only in marriage. It is limited to sex for having children and to satisfy her husband. She becomes the property of her husband, whatever he does. The sangha women were quite open to talk of their sex lives.

My husband lives with another woman. He comes home for a few days every month. Before I had my operation and my womb was taken out, he used to want to have sex with me, too. I used to wait for him - but everything used to happen so fast. His lingam got erected, and for him I was just a hole. He always did it on top of me. Then, he would turn around and go to sleep, while I would be awake all excited. Sometimes, I got that big surge of pleasure after he had turned his back on me! Once I woke him up, and he shouted at me angrily, 'What do you want? Since when have you become like those women? Go to sleep!'

As unmarried, deserted or widowed women, we have been forced to suppress our sexuality, or else be available for all. All of us, single or not, wanted greater control and more options.

Since my husband died ten years ago. I feel very lonely. I do have sexual urges. My brother-in-law stays with his family alongside my house. During summer, it is impossible to sleep inside. I sleep outside along with my three sons. My in-laws realise I'm still young, yet in front of me they relate sexually, and it hurts me. I want to experience sexual pleasure - is it possible?

I'm nineteen, and I'm a widow. I would love to have sex, but I'm afraid of pregnancy. Men get attracted to me since I'm single and good to look at. But in my caste, I can not remarry.

Relations are painful for me - my yoni is small.....

Men are almost never sensitive to women's sexual needs. Women can't ever say 'no', and often submit several times in the day or night.

My husband has strong sexual urges. He wants to have sex every day, and more than once. It's only penetration, and I'm tired of it.. He tells me to eat well so that I can satisfy him.

Among the married women, some said they disliked penetration by a man and had to bear it only to get pregnant. Some of the others said it gave pleasure, like Lakshmi Narsamma.

I look forward to it - hai, ga! It gives me a jol-l-l-ly feeling!

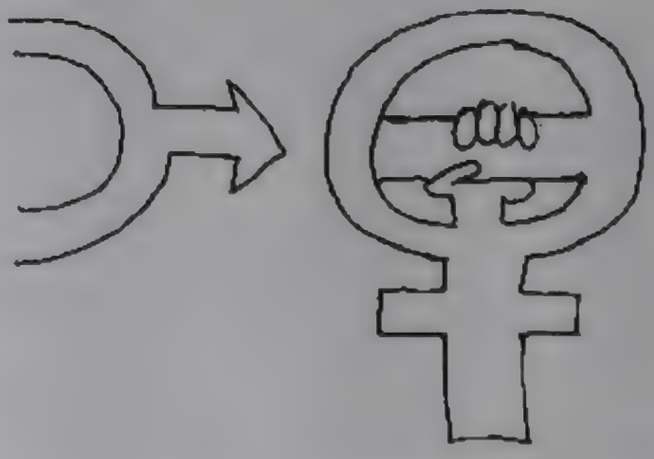
But, because of husbands' sexual behaviour, many women get health problems which they can't reveal.

My husband has sores on his lingam, and whenever he has sex with me, I get severe burning and itching in my manam.

A woman who refuses sex gets labelled as 'frigid', or accused of having other relationships. Our participants said that most often women just want physical closeness, warmth, appreciation and assurance.

I want to be embraced, to be kissed, just to be near him, but I'm scared to tell him - he'll think I've learnt it from others.

Women would like to explore their sexuality. But, all our life, we get messages about how to behave.



Double Sexual Standards

Through an exercise, we looked at the *double sexual standards* for men and women. The participants were asked to think of descriptive phrases that people use when they talk about the sexual behaviour of men and women.

A Man	A Woman
he's a charmer	she's a flirt
having sex proves his manhood	she's a loose woman
he's a he-man, he's great	she has no shame
he moves like a raja (king)	she's a whore
he's a woman-killer	she tempts and traps men
why marry if he can have sex anyway	she needs a man to control her
he's a carefree bachelor	she's unmarried because she's ugly
he's waiting for a large dowry	she's cranky because she's frustrated
a man's never too old for sex	she's mother of grown-up children,
he's handsome	....but so much fat (sex urge)
he's been building up his career	she should be satisfied being a mother
he's sowing his seed	she looks ill, must've had an abortion

The phrases reflect a positive image of men's sexual behaviour, while for a woman, it portrays an image of deviance. For a man, to be sexual is normal and good, while for a woman, it is abnormal and bad. The stereo-types reflect society's double standards which permit men to act as they please. A woman who demands control over her own body is just not thinkable within the stereotypes.

'Orgasm'

Orgasm is a small aspect when it comes to talking of sexuality, but it is important because of its politics. Women are always given to understand that to reach orgasm, they need a penis to penetrate their vagina. Only then, they are supposed to reach that height and release of sexual pleasure which is called orgasm..

Our women's experiences of sexual pleasure were different. Most of them did not feel need for penetrative sex. They had experienced pleasure by stimulating their breasts and other sensitive areas, like the clitoris. They questioned,

Why do we always need to be down, when relating? And the man always on top. It makes us feel so helpless.

I find great happiness just by someone touching me, stroking the back of my neck.

One said she got repeated orgasms afterwards but dare not mention it to her husband.

It is a myth that vaginal penetration itself is pleasurable. The inside of the vagina has hardly any sensation. Because women's sexuality has been mystified, distorted and controlled, learning about the clitoris and about orgasm by direct experience is *a political action* which challenges the oppression of patriarchy.

It is also important for women, and even for men, to validate the experience that *orgasm is not the end-all of sexual response*. Feelings of shared comfort, warmth, gentle fondling and subtle sensations of sensuous pleasure can be just as meaningful.

Defining Sexuality Beyond Sex

What is 'normal' to society is also argued to be biological. Sex between men and women only is considered natural and healthy. But, society shapes and limits our sexuality. For women cast in different roles, sexuality gets constructed in different ways. Woman's sexuality is influenced by class, caste, race, age, disability, and so on.

After a lot of reflection, we defined *sexuality*.

> *Sexuality is a powerful, free inner energy of human beings - physical, emotional and intellectual - which relates with our social and physical environment. It is a source of refreshment, pleasure, and passion which increases our self-confidence and creativity.*

Sexuality of Single Women

Among us were four women who had lost their husbands at a very young age. These women were exposed to all kinds of restrictions to kill their sexual urges.

Ever since I started attending the training, I am feeling stronger and different. I wear bright coloured saris, eat like a normal person, powder myself, wear a bindi - which I have never done since I was fifteen years... I feel sexually active. Even my walk has changed. At first women in the village passed remarks, saying that the change in me is due to the training. But now they have got used to seeing me like this. I used to close my eyes while having my bath. Now I look at my body freely. I feel my mucus with my fingers to chart my fertility... I feel really young and so free within. Felt like a caged bird all these years. Can't I have sexual urges, though I'm thirty-six years old!?

Women's sexuality is not only dictated by norms in the family, but also in the community.

One of the project staff participants was a widow who was in a relationship with a male colleague. These sessions gave her a sense of control over her body. She decided that there was no longer need to be silent, and she began talking openly about it among her project team members. It blew up into a crisis in her project, and the self-help training was blamed. The male co-worker lost his job, and the woman was allowed to continue in her project only when she agreed to stop seeing him.

Another participant tells of her attempt

I was asked to replicate the training in my sanghas. I used the pictorial charts to explain to the women the parts of the body. As we were doing this, men got curious and peeped through the windows. When they saw and overheard, they were angry we were discussing a topic that was taboo. They raised a hue and cry, and next time they stopped the women from coming to the meeting. So, Akka, it's not only that we can't have a relationship. Even looking at pictures and talking about our bodies is threatening to the men.

Sexuality in Older Women

We have all grown up in an environment which propagates the myth that sex is only for the young, and older women are sex-less. There is no basic reason why we cannot enjoy sex for as long as we live. Many women in their fifties experience a re-awakening of sexual interest once they no longer need to prevent pregnancy and once the pressures of child rearing are passed.

Menopause is a natural event. It is not the end of life, or all productivity, nor is it the end of sexuality. It marks only the end of biological fertility. It is a period of hormonal changes which may last several years. If we are aware about our changes, we are able to cope with the adjustments of this phase.

Modern medicine proposes sedatives, tranquillisers and hormone replacements, which have adverse effects on our health. Self-help advocates another approach. Stay active, feel useful, love and be loved, continue physical exercises, express oneself sexually, and eat well.

Other Sexual Expressions

Women had lived in guilt about the ways they had tried satisfying their sexual urges. Some of us discovered stroking and rubbing parts of our body gives us pleasure, but we have done it in a guilt-ridden secretive way. Now, it could become part of our self-discovery.

Other ways of satisfying our sexual needs could be caressing and stroking, hugging, body-to-body rubbing, massaging, kissing, taking a nice hot oil bath, singing and dancing, seeing a film, listening to music, and fantasising. There could be many more ways, too.

Women to Women Relationships

When I was young, my female cousin and I hid behind the hay stack. We use to feel each other. I didn't know what it was that gave us such pleasure. Today, both of us are married, but we love to be together even now. We feel so free beside each other, and we talk and talk.

Relationships outside marriage and women-to-women bonds are not uncommon, but the stereotype of monogamy and marriage dominates. It crushes these other relationships. We wanted our group to realise that such ties between women are natural and healthy, and we should create spaces to encourage these expressions .

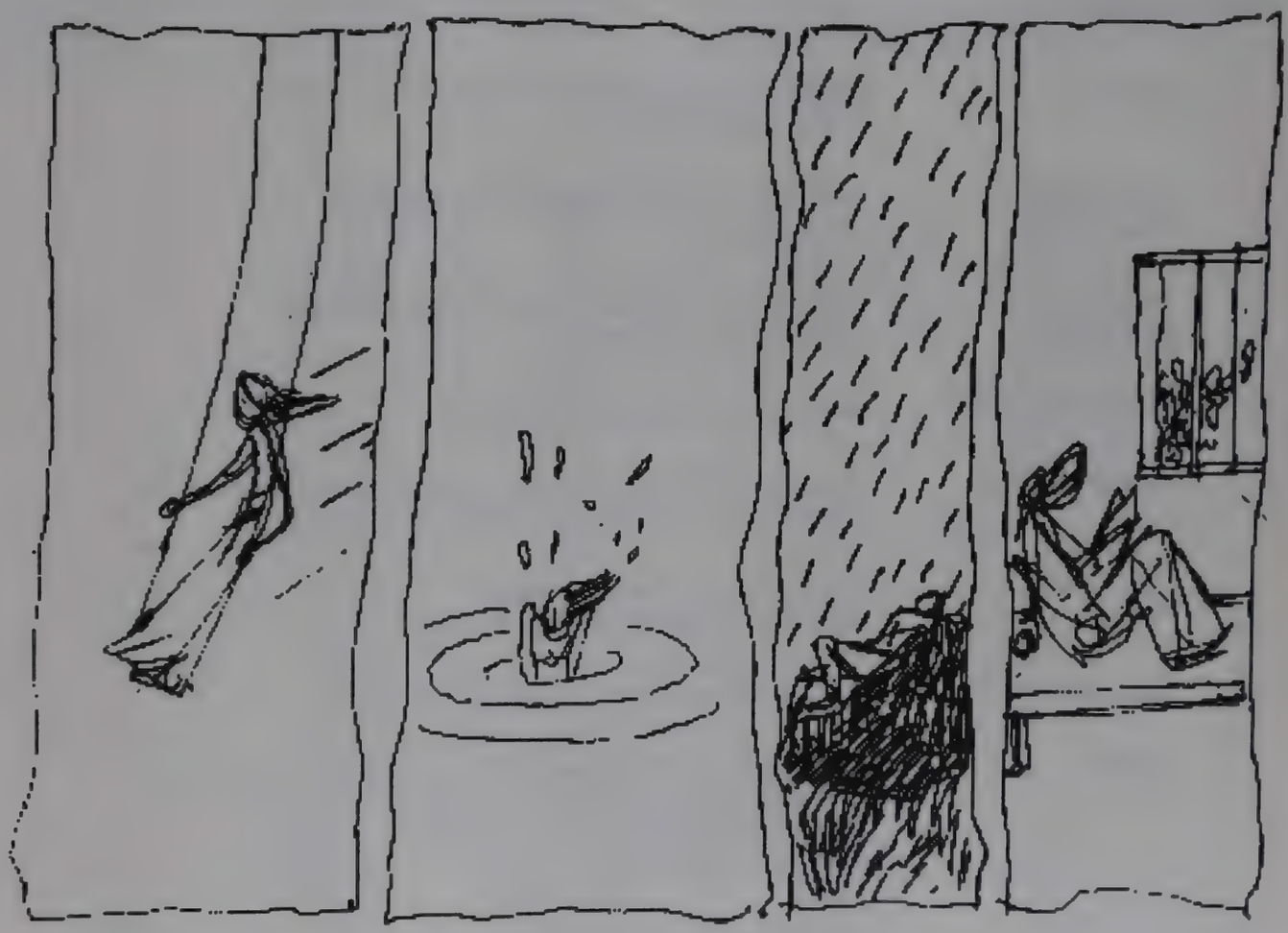
The thought arose, mixed with surprise and laughter, that we did not need men to satisfy our sexual desires! We could give pleasure to ourselves and to each-other.

As man-woman politics is minimised in woman-to-woman relationships, it becomes *possible* to explore what pleasure can be - to give scope to all the senses.

Our group became very clear that sexuality relates with our body *in totality*. In order to live fully, we need to express sexuality. It evokes our inner-most feelings and aspirations. Back at their work place the participants began to create spaces for themselves and other women.

Some in our group expressed too well what control over one's body means. They said it like this -

Nā shariram nādhi! *My body is mine!*



Self-Help and Self-Exam

Objectives

- to deepen our understanding of self-help as women's empowerment
- to develop skill in 'life-story' taking, basic for understanding a woman's problems and counselling
- to learn 'self-exam' skills and healing
- to learn about food, and its effects on our body and explore ways to get enough food
- to understand the limitations of various systems of medicine
- to encourage the use of women's traditional healing knowledge of herbal remedies
- to visualise and plan 'women's resource centres'

Methodology

Exercise:	depicting health problems on an outline of body, and attention given
Life-Story Worksheets:	to connect present health problems with life experiences
Well-Woman & Self-Exams:	whole body, then breasts, belly, chest and back, vulva, vagina and cervix
Speculum Exams:	seeing the vaginal walls and cervix
Bi-Manual Exam:	to explore the inside of pelvis - vagina, cervix, womb, ovaries and egg-tubes, and other soft or bony parts
Cleanliness Practice:	cutting nails and washing hands caring for rubber gloves and speculum
Chart Making:	foods, food habits and food qualities
Activity:	physical remedies and exercises collecting medicinal plants making a herbarium making herbal remedies
Video-film:	MEDICINES AT OUR DOOR STEP
Visits to:	a local traditional medicine market the herbal medicine project at DDS

A Deeper Understanding of Self-Help

A self-help approach is based on valuing the *experience* of oneself and one's group, or one's community. Through self-help we also gain and re-claim information which for years has been kept from us in the hands of physicians. Self-help challenges doctors' control of health care and modern medicine's abuse of 'gyn-ecology'.

Self-help is an alternative approach which focuses on *health rather than disease* and on natural *re-balancing remedies* rather than medical or surgical interventions. With a self-help approach, we don't wait for an illness to come and attack our bodies, but seek to live a healthy balanced life.

Health is the most fundamental aspect of a person, natural and inseparable from life. Health must not become a commodity to be bought in the medical marketplace, without which women must suffer or die for lack of money. Our *right to protection of health* is fundamental.

Self-help happens in a group. Only here we can emerge from self-doubts and isolation to find that other women share some of our experiences. We come to trust our own perceptions with a new sense of power. Self-help is about sharing and grasping information and gaining control over decisions concerning our lives. Together, we learn about our bodies and our rights.

Imbalances in Our Health

While we want to focus on 'health', the *reality* is that we have lots of disorder in our gyn-ecology! As a whole group, we explored how we feel about our health problems through an exercise.

⇒ We drew two life-size body-outlines on two separate sheets of paper, for the front and the back of our body. The first part of this exercise was to make markings on the body outline depicting any health problem or symptom we have ever had. The second part was to mark in a different colour the problems for which we have got treatment from a doctor.

On the outline chart, various problems were marked over the head, eyes, neck, the whole back, arms and legs, and upper and lower belly, and vulva. The group suggested the reasons, as follows:

Problems	Reasons
pain in head, eyes, and neck	emotional strain and stress
backache, painful arms and legs	heavy work, white secretions
upper belly pain and burning, gas	acidity, hot food, emotional stress
lower belly pain, heavy or irregular bleeding	'something wrong' inside; a vague idea of 'infection'
pain in vulva, white secretions	general weakness, painful sex-act
womb descent	difficult childbirth, carrying heavy loads
most of the above	appeared or got worse after 'operation' (tubectomy)

The second part of the exercise showed how little care we are able to take of ourselves.

⇒ *Most of us have got treatment only when we could no longer bear the pain.* The disorders which we took to doctors were general weakness, backache, headache, joint pains and burning in the stomach.

⇒ *It was easier to mark 'usual' kinds of problems*, as we relate them to general conditions in life. But, we hesitate to mark genital and urinary ailments. We are ashamed about these, and we fear being punished by husbands and abused if we go to a doctor.

The experience of the women in our group was just a reflection of what was happening to women everywhere.

We wanted to start a friendly process where women will feel free to attend to all their problems at an early stage. Self-Help creates space for all women. Instead of taking a 'medical history', we decided to trace each woman's *life-story* as a basis for understanding her *health*.

Learning about Life-Stories

While listening to *life-stories* we develop skill in seeing the totality of a woman's life as it relates to her present problems. We listen to each other carefully and sensitively, beginning with the problems she has at this moment. For example, if she is troubled by back-ache and 'white discharge', we would ask her what she thinks are the causes. Usually she has something in mind and gives some important clues. From here, we go back with her through her life - her childhood, growing up, her family and other relationships, her work, the food she eats, and so on.

We designed and used a life-story sheet (see at the end of this book), modifying the one used by the Shodhini project. We wrote in her language, using her words. We made use of sketches and simple, understandable symbols. One has to decide about writing while listening, or to write later. If you fill out a proforma in her presence, you must explain to her how and what you are recording, and why.

Our life-stories help us to know

⇒ how our present problems may be linked to our past,

⇒ what important things should be noticed when doing an exam, and

⇒ what approach we can take to promote health and healing.

LIFE STORY SHEET

Name: Age:

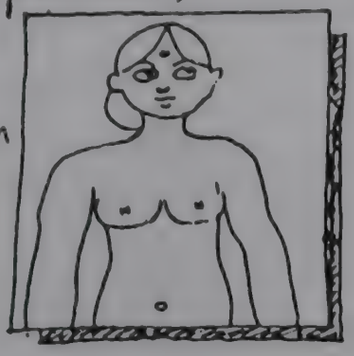
Village: Date:

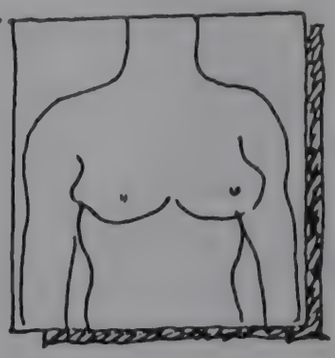
Life Story

Present Disorder

General appearance:

Breast Exam



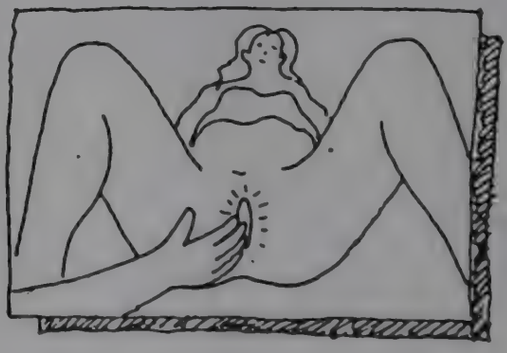


Any Problem

Belly Exam

Speculum Exam

Bi-manual



Secretions

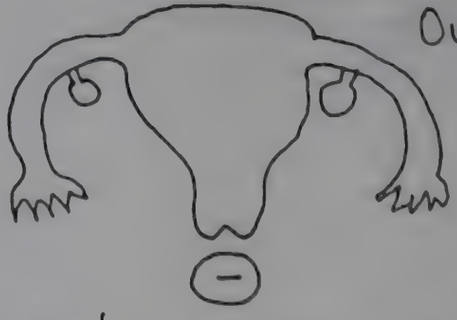
White

Red

Yellow

Pink

Disorders of Womb and Ovaries



Attach Extra sheet for healing advice:

Self-Exam and Well-Woman Exams

It's not an accident that the question *Am I normal?* keeps repeating in many women's minds. The medical system has promoted and benefitted from this doubt. Rejecting wrong ideas of our bodies being uniform and respecting variations is a basic aspect of self-help practice. Carrying each one's multi-coloured life-story with us, we began learning self-exam.

For the ***whole body exam***, we saw each-other in pairs, as a *role-play* exercise.

While observing our partner's features and body parts, we would keep talking with her softly. First, we took notice of

⇒ *positive qualities and signs of balanced health* (whatever they might be) - in her attitude, her confidence, quick-ness or calm-ness, the firmness of her limbs, smoothness or glow of her skin and hair...

Then, we turned our concern to finding and noting

⇒ *signs of health possibly out of balance*, like tiredness or tension, thinness, height, pale-ness of her skin, dullness of eyes or face puffiness, swollen feet, rashes or marks, pain in some places, and so on.

⇒ also, any *deformities or disabilities*.

⇒ We learned to feel each-other's pulse.

For the ***belly exam***, We continued practising in pairs. We asked our partner to pass urine. She loosened her sari and skirt to show her belly. She lay down flat on a floor-mat, slightly bending her legs to relax the belly muscles.

⇒ Recalling the problems your partner had expressed, *did she have pain in the upper or lower belly? Was it accompanied by burning? Did she ever feel like vomiting? Did the pain increase by eating, or on an empty stomach? Did she feel relief after vomiting? Was she constipated? Was this accompanied with fever and shivering? If there was pain in the lower belly, was it related to periods, to having sex, to any contra-ceptive method?*

⇒ According to the problem, we decided how to proceed. We imagined the belly divided into four - right and left upper and lower parts.

We looked at her whole belly for any swelling, difference in colour, scars, rolling motions, pulsations and so on.

Rubbing our palms together to warm them, we felt each part of the four quarters with the flat of the fingers, pressing and lifting. If there was any swelling on the right upper part, closer to the ribs, accompanied with pain, it could be a problem with the liver. If it was the left upper part, it could be an enlarged spleen. If the central portion above the navel was painful with burning and nausea, it could be ulcers in the stomach or gut. We listened for gut sounds by pressing our ear against the belly.

In a similar way, we felt the *lower belly*. On the right, just inside the pelvic rim, if there was pain, it could be the appendix or due to amoebic infection. Towards the lower mid-belly, if there is pain in the middle or to the right or left, it could be swelling of the womb, egg-tubes or ovaries. To confirm this, a bi-manual exam would be needed.

For her ***chest exam***, our partner now opened her blouse.

⇒ Looking at the chest, back and front while she sat up, we noticed the way the ribs went in and out with her breath. *Was her breathing regular, fast or slow? Was she breathless, and was there any wheezing sound?*

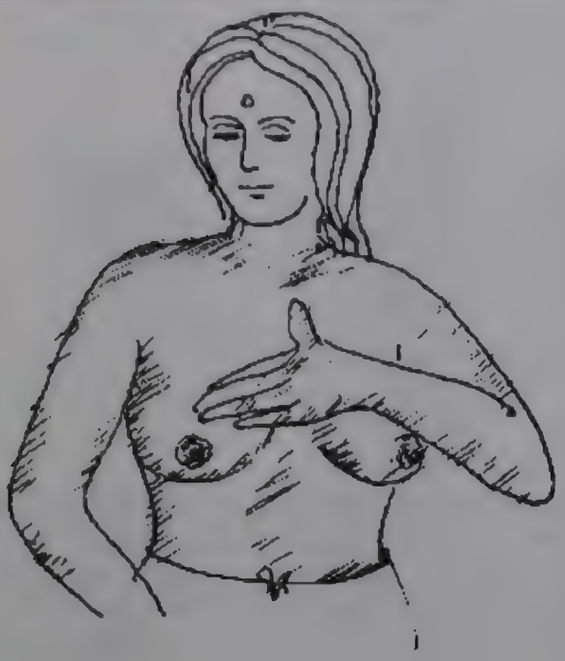
⇒ Then, we looked where the heart knocks the chest wall. We felt for the heart-beat with our fingers.

⇒ Next, we knocked and found the hollow sound of the lungs on the sides and back, and dullness over the heart.

⇒ Lastly, we put our ear over the heart and lungs to listen to the heart-beat and to the breath sounds.

Breast Self-Exam

We each took turns and sat in front of a large mirror to do our own breast self-exam.



We looked at

⇒ the size and shape of each breast, and their differences

⇒ the skin surface and any irregularity, scar or raised lump

⇒ the nipples, seeing whether they stick out or inwards, and pressing them for any secretion.

Then, we raised our arms over our heads and saw whether

⇒ the skin pulled or seemed tight, or puckered.

Next, we placed the opposite hand with fingers flat, and with circular motion we felt one quarter of each breast at a time, covering the whole breast. We worked carefully from the nipple outwards, looking for

⇒ changes or lumps deeper under the skin, and

⇒ lymph-nodes and cords in the armpits which may be enlarged.

The size and shape and other features of *healthy breasts change with the hormones* of the menstrual cycle. The best time to do a *monthly* breast exam is a few days after the period ends, as now the effect of hormones is the least.

Vaginal Self-Exam

We need a torch, a mirror and a speculum for vaginal self-exam.

We got familiar with the transparent plastic ***self-help speculum*** - its smooth, rounded blades - and practised opening and closing it. We held it with the *handles upwards,* opposite to the way doctors hold a speculum to examine women!

We got into a sitting position leaning against a wall, so that our belly muscles relaxed, with our legs bent and apart. Then, with a mirror each of us examined her own vulva.

We saw and felt the parts, one-by-one - the pubic pad, the clitoral glans, hood and shaft, the outer and inner lips, the urine opening, the vaginal opening, the hymen fringe, the anus. Some were more sensitive, some were less.

We looked for any problems, like swelling, redness, scratches or rash, ulcers, infected hair follicles and lice in the pubic hair, and or any infected secretions.

Next, we put a finger inside the vagina and noted the direction of the vaginal passage. We spread the inner lips of the vulva with two fingers of one hand, and held the speculum in the other with the blades closed, initially with the handles sideways. Then we gently guided the speculum into the vagina.

Once the speculum had gone up the length of the vagina, we turned the handles upwards. Next, we pinched the handles to open the blades, and clicked the latch. This stretches the vaginal walls and keeps them apart, revealing a view of the cervix.

With the speculum locked, both hands are free to hold the mirror and the torch. Or, you can hold the mirror between both your feet. Now, we flashed the torch-light on the mirror and adjusted it to reflect into the vagina, lighting up the vaginal walls and the cervix.

The walls of my yoni are pink inside, and they're folded and crinkly. My cervix is pointing straight towards me!

My cervix looks like the end of my nose.

I can see the hole in the middle which is opening into my womb!

It's very near my ovulation time - my cervix is lifted up, and the mouth of my womb is open!

With the blades still open, we removed the speculum. All of us had some secretions on the blades. We noticed the amount and colour, and we smelled them, too. This was to see the difference between normal secretions and the discharges caused by infections. Since we did this in turns, all of us were able to see the self-exam of others, too.

We couldn't believe, with such simple things as a speculum and mirror, we could see what was hidden from us all these years!

When all the rest had finished, one of us was still not ready. We were surprised at her hesitation. All these months, she had been participating actively. We gave her more time. The next day she did examine herself, and she was relieved. Slowly, she told us that she was afraid she had an infection from her husband, who has sex with other women.

When one of our happy-go-lucky participants inserted her speculum, she was faced with heavy frothy discharge flowing from her cervix, and smelling bad. Embarrassed, she reddened for a few seconds and became withdrawn and quiet. Then she tried to give a series of explanations for the discharge. We listened to her. Slowly, she seemed to accept that she had an infection.

Another shared,

I always wanted to have a check-up - my lower back gives me a lot of pain. I was surprised to see my vaginal walls red and sore. My cervix looked very red and angry! It is an infection.

Vaginal ***speculum self-exam*** of the cervix was truly liberating for many of us, especially Nageshwari. Until this, she had been arrogant and aloof. Having had formal ANM-training, she thought herself one above the others. A doctor had told her that she had 'severe prolapse of the uterus'. But she found her womb had merely lowered in her vagina (mild descent), and she had an 'angry looking cervix'. She was relieved it was not as bad as she expected. The speculum self-exam made a big difference in her life and in her relationship with the group.

Speculum exam has been one of the most empowering things that happened for me. I feel so different today. I feel confident of myself.

The ideas of *normal* and *abnormal* alienate women from their real physical selves. Thus, society makes us feel ashamed and afraid of our genitals, and we imagine that our body is somehow *sick and defective*.

I have scabies marks on the inside of my thighs and manam. Doctors always called me dirty. I was afraid you all would react, too. But no one laughed, no one passed a remark. You all gave me respect.

Some of us had problems with insertion.

I was afraid to do self-exam. I had a lot of fears about my sexual parts. I was afraid I had an infection. But, seeing my cervix healthy with no discharge relieved me.

It was painful when I tried to put in the speculum. It was big, and besides, I was tense. I wish there had been a smaller size for me.

It is important for future self-help work that we get speculums in *different sizes*. We feel the design can be modified slightly. Manufacture of self-help vaginal speculums in our country would be cheaper.

The next step in training was to go on to bi-manual exam, but we noticed that Ramalamma was very upset. So, we stopped at this point in order to listen to her, and to Nagamma, Nageshwari, and Sathyavati and to decide together what they could do. We will be discussing the disorders they had to contend with in the next section on Gyn-Ecological Disorders and Healing.

Learning Bi-Manual Exam

With the speculum, we had *seen* into the vagina up to the cervix. To assess the size, shape, consistency, position and moveability of a woman's womb, the condition of the ovaries and egg-tubes, and the surrounding pelvic soft-parts and bones, we learned to do *bi-manual pelvic exam*. 'Bi-manual' means that both hands are used - one with two fingers in the vaginal canal and the other pressing toward it through the lower belly. We 'see' with our two hands.

If bi-manual exam is done by another person *on* a woman, there is always a possibility of a woman feeling intruded upon or violated and powerless. Women feel this way with most doctors. From a self-help point of view, it is important to enhance a woman's sense of power and help reduce her passivity. You can involve her actively in helping you do the exam. You can do the bi-manual exam *with* her, *not on her*.

Each of us chose a partner for bi-manual exam.

⇒ She should empty her bladder first. Meanwhile, wash hands carefully with soap, making sure that nails are clipped and clean. See that she is comfortable. Keep gently talking with her, always telling her about the next step. *Ask her to keep telling you how it feels* - the sensations, and any discomfort or pain. She lies on her back, now raising and bending her legs. A *clean* rubber glove may be used on the hand, but is *optional*.

With two fingers of one hand, separate the inner lips of the vulva. Insert the other hand's middle and index fingers, and first feel for the ***vulvo-vaginal glands*** (you'll only feel them if they're enlarged). Press slightly down as your fingers move inwards. Feel the texture of the ***vagina***. Move on up to the ***cervix***. With your two fingers in a 'V', note it's size, firmness, position and moveability. Are there any small bumps or growths? With one finger, see whether the ***mouth of the cervical canal*** is open or closed. Is the opening round or slit-like, and are the margins smooth, rough or ragged?

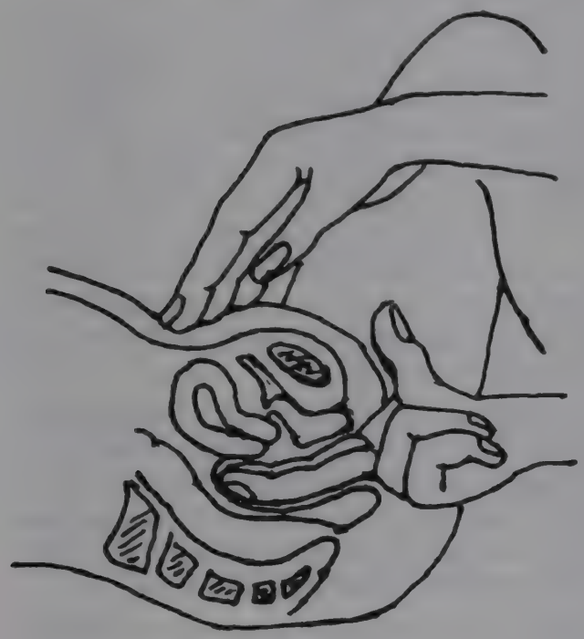
Now, put your other hand on her lower belly. Press downwards firmly, but gently. This pushes her ***womb*** down so you can feel it between both your hands. With your vaginal fingers in front of the cervix, feel to see if her womb leans forward. If you can't feel her womb, then place the fingers behind the cervix. Try lifting it. The womb may then move forward, and you can feel its *size, smoothness, firmness, moveability and any tilting* to right or left. If the womb is still difficult to feel,

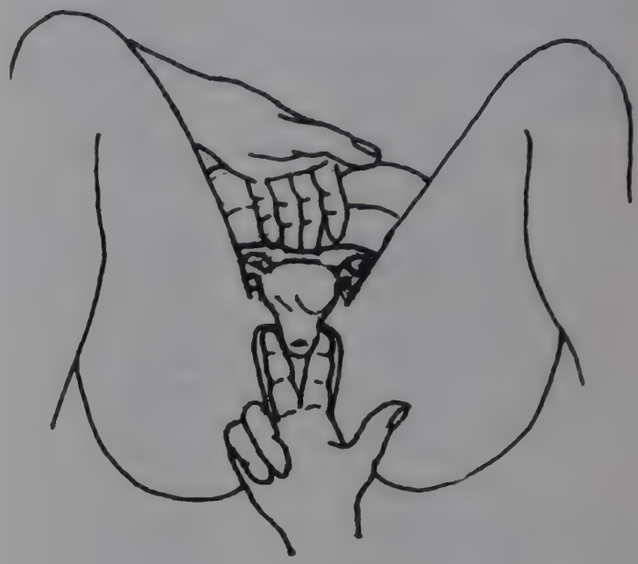
it may be tilted backward. Having a back-ward bending womb is not so common, but it is not abnormal either. But, note if it feels *fixed* to the other structures. Is it painful?

Next, feel for the ***ovaries*** and ***egg-tubes***. Move your hand over to one side, and the vaginal fingers to same side. If your partner is thin, your two hands may almost meet each-other. Try to feel the ovary and tube on that side. The ovaries are very small and the tubes almost impossible to feel it they're not swollen. It takes practice to feel an ovary. As you press it, your partner will feel a *twinge of pain*, so be gentle. Now, feel the other side.

It is not so easy to do bi-manual exam, and have a sense of knowing what you are feeling through you hands. Your partner can feel like a whole expanse of ocean inside!

We found it difficult, and we needed a lot of practice. We repeated bi-manual exams on each-other for several months until we felt confident to do it with other women.





Cleanliness, and Taking Care of Speculums and Gloves

We learned the importance of *cleanliness* much before the session on Self-Exam. In the group,

- ⇒ We regularly practised removing rings and watches, hand-washing, nail cutting and scrubbing, and
- ⇒ We practised wearing and removing rubber gloves, and how to clean them, disinfect them, dry them in the shade, and powder them; then, to fold and pack them ready for the next use.

Immediately after self-exams, the women washed the secretions off *their own* speculum with soap and water. Then, they soaked them in a bucket of disinfectant solution for a few hours, if not overnight. Then the speculums were dried on a clean cloth in the shade. When dry, they were packed into containers.

At first, we had asked the participants to wash *each-other's* speculums. One has to touch secretions on the blades, and there was a lot of resistance. They would just pass the speculum through running tap water. It took time and effort to convince them that vaginal secretions are as clean as the secretions from our eyes or nose.

After we had completed the various exams, each one recorded what she had seen and learned about herself on her life-story sheet.

Aside from the experience of self-exam, and our new observations about our bodies, we talked about each one's problems, and healing measures for them.

Foods and Their Effects on Our Body

Several of us found that we had *yeast infection*. Since this condition results from disorder in our body and vaginal ecology, we thought we should talk about *hotness* and *coldness* of foods. The concept was well known. It made sense to them that what we eat can affect our secretions. They could recall experiencing this. Besides they even added that each of *our bodies are also hot or cold by nature*. So it is not just the foods, but also our body constitution. Hot foods quicken digestion and so increase acidity - this would make vaginal secretions more acidic than usual.

We divided up the foods we eat into hot and cold categories.

HOT	COLD
bajra, rice	ragi
oils, oilseeds	jowar
jaggery, honey	wheat
horse gram	tuvar dal
black gram	moong
potato	pumpkin
garlic, onions	leafy greens
papaya	gourds
chillies, pepper	guava
tamarind, ginger	amla
methi seeds	jackfruit
ajwain, mustard	raw mango
sour curds	fresh curds

We differentiated *redness* caused by infection and redness which is healthy. In *paleness* of the vaginal walls connected with anaemia, it was necessary to eat foods with more iron. In menstrual disorders, like excessive bleeding, we encouraged foods containing *calcium* and *iron*.

Our women linked cropping patterns, seasons with foods and our health. They said that most major festivals came in winter from October to March, when food was available.

We did an exercise to list the food grown and produced in our areas in the past and now. We found that,

⇒ *In the past*, there was jowar, ragi, rice, jaggery, groundnuts, various beans, grams and dals, chillies, mustard, and many more. The *cropping was mixed and diverse*, and people were able to grow everything they needed locally.

⇒ *Today*, the cropping pattern has changed. Indigenous crops like jowar, ragi and many dals are disappearing, replaced by new *cash crops* like sugar cane, tobacco, cotton, oil-seeds and mulberry. Cane is now produced for sugar factories, not for jaggery. Rice and groundnuts are *hybrid* varieties.

Next, we worked out how many meals we eat a day and what we eat. Surprisingly, there was not much difference in the diets of the project staff women and the sangha women. All of them said they have two meals a day.

⇒ *Rice* is the bulk, eaten with *watery dal or rasam* (chilli and tamarind water). Only the project women can afford watery buttermilk, and home-made chutneys and pickles. Vegetables are bought only on weekly market days. A little meat or eggs are eaten only about once a month. Women usually are left only with thin gravy and *bones*. Everything is cooked with lots of *chillies*. They hardly ever eat fruits, not even bananas. Only during the monsoons, they grow pumpkin and other *gourds*, and they collect different kinds of *greens* from the fields.

Most of the participants came from marginalised background with barely an acre of dry land working as wage labourers earning Rs.10/- a day. It was easy for us to talk about nutrition, but how practical was this when everything is so expensive. Even dal today costs Rs.32/- a kg.

Is it fair to ask them to be selective about foods, when their bodies need whatever they can get?

The whole session on food sounded ridiculous. Yet, food is important! We had to go on.....

The participants' usual food at home was heating to the body, and could be related to some of their problems. Wondering whether the situation could be improved, we decided to look at the foods at our training centre, six days every month. We had three daily meals.

⇒ At mid-day and evening meals we had rice, a thick dal, a vegetable, curds and chutney or pickle. The food was usually spicy, and enough oil was used. Thrice a day we had coffee or tea.

Our meals at the centre were tasty and nutritious, but they had a lot of hot elements like oil, pickles, chillies and spices, tea and coffee. So, we made some adjustments.

⇒ We skipped tea and coffee, having cooling herbal teas and cool buttermilk instead. We had salads and sprouted pulses. We cut down on pickles and chillies. For snacks, we boiled

groundnuts and grams, and had seasonal fruits instead of biscuits.

⇒ Every morning each of us ate a clove of garlic!

We kept to this *new diet* every month. Even within six days, we noticed improvement. The yeast infections cleared up, and we felt better.

Ensuring that we get *enough food* is a part of self-help. We stretched our brains to figure out ways despite conditions of poverty. Lakshmi Narsamma said she would work with the sangha women to do *back-yard gardening*, and this would help to get some vegetables into the diet. They thought they could work through the mahila sanghas to see that the *ration shops (PDS)* function properly to have rice, oil, jowar, maize, ragi and pulses available at low prices throughout the month. The idea of *grain banks* was thrown open.

Body and Pelvic Exercises

Every morning we did our regular exercises. Some exercises are especially good for strengthening our pelvic muscles which support our womb, bladder and rectum. They also loosen up our tightness about the lower parts and can help to put us in touch with subtle sexual sensations.

Nageshwari and Pushpa had mild descent of the womb. We worked out and practised the following exercises for ***strengthening our pelvic floor muscles*** -

⇒ Lie flat on your back with your arms resting by your side. Slowly raise both feet five inches above the floor; keep them raised for ten seconds, then lower them. Repeat this 25 times, morning and evening.

⇒ Contract your pelvic floor muscles hard and then release them immediately. Repeat this 25 times at least twice a day. This exercise can be done lying, sitting, standing, walking and whilst working.

⇒ While you pass urine, try stopping and starting the flow. If you can stop the urine, your pelvic floor muscles are strong.

⇒ Put two fingers into your vagina, and try tightening around your fingers for a second, then release, repeating it 10 times. Do this once a day.

⇒ Kneel with your chest on the floor and bottom raised in the air. Do it many times in the day.

⇒ Lie down and bend your legs at the knees; pull your buttocks up 3 inches above the ground; breathe in and contract your belly muscles. Relax while going down, and breathe out. Do it 10 times twice a day.

We also pooled together our knowledge of massages and physical exercises which are helpful, like

- part by part, relaxation of the whole body,
- certain yogic *asanas* and breathing exercises,
- lower back and spinal massage, and
- lower belly massage over the womb.

We learned and practised some pressure points for menstrual cramps, heavy bleeding, tension, back pain and for stimulation of energy. After doing such exercises regularly, we felt better and stronger.

Counselling

One by one, we took up each-other's problems. One wanted to talk urgently. She feared she had got the infection from her husband. Up to then, she had not accepted that he was going to other women. She knew about the need to avoid intercourse until her infection heals, and had to confront her husband about it. He needed to get treated as well. She had to persuade him to wear a condom, or to find other ways of relating sexually with her. We urged her,

Now that you know about it, you need to take steps to heal yourself. Your health is important! Don't neglect yourself and put up with abuse, just to satisfy him...

Self-help counselling is a process to strengthen a woman's sense that *she can help herself*. Mainly, counselling is *being with her*, close, listening to spoken and un-spoken words, sensing her tenseness, her worries. With your touch of hand, your warmth and concern, she is assured of your trust and respect.

As a *self-helper*, you are

- *a friend whom she can trust.*
- *a fighter for women's rights, and*
- *an activist for change.*

You may have no solutions. But, with your support and your help for her to link her experience with others, she can make decisions in her life which make a difference.

Bringing Herbs from Home

From the outset of the course, our participants had expressed keen interest in herbal remedies. Whenever there was free time, they exchanged knowledge of herbs with each other. Pushpa had shared many herbal remedies. After self-exam, there was a six-day session at Hyderabad on *herbs and remedies*. The women came prepared with various plants, flowers, roots, fruits and seeds from their villages.

Self-help is an effort to re-identify and re-claim what we have lost and validate the healing resources within us. Reviving the use of herbs to maintain our health is part of building an autonomous and self-sustaining alternative to the destructive trends of modern medicine.

By reviving the use of herbs and other therapies, we do not deny modern medicine a place in healing. We have to look at the health systems in a balanced way, as each has its own historical and cultural context. With the development of medicine as an industry, women have been systematically dis-possessed of knowledge, and are losing control of their role as healers.

Modern medicine's approach to women's health has been characterised by treatment which suppresses symptoms without identifying and tackling the real reasons. Consequences of such treatments have been harmful for women, especially when most women are malnourished, anaemic and underweight because of poverty and discrimination. In a world where women are negated

or marginalised, we need to work our women-centred alternative.

It was an eye-opener to see how much each one knew.

Pushpa failed to turn up, as her son was ill. While Subbamma hadn't shown special interest in herbal medicines up to now, she surprised us and nearly took over the session! Her father-in-law was a *local healer*, and she had been learning with interest since childhood.

We learned how to make a collection of herbs in an album, called a *herbarium*. The medicinal plants brought from home were distributed among ourselves. Each one of us pressed her own specimens between newspapers and kept them under weights. A few days later after they had properly dried, we mounted them in the herbarium. At the end of the several days, each had her own herbarium ready. Those learning to read and write had been encouraged to do all the writing themselves. On each sheet was written the name of the plant, the parts to be used, properties, preparation, dosage, the effects on the body, the method of use, and for what ailments.

Meanwhile, Subbamma's first demonstration of preparing a remedy was to make a powder of *thippathiga* stem *(guduchi* or *tinospora cordifolia)*. It was to relieve heavy menstrual bleeding.

We learned how to process and prepare herbal medicines. All herbs had to be first washed well, and then dried in the shade. The herbs were stored in dry form, or powdered and packed. We prepared *triphala* powder of *amla*, *baheda* and *harda*. *Ashwagandha* root was powdered and packed.

Remembering our self-exams, we talked about the various remedies. During the next few months, we regularly tried out remedies for women's common problems, and kept records of their effects. Here, we give you remedies which we found effective.

During this six-day session, we arranged to see the video-film prepared by DDS health workers, called MEDICINES AT OUR DOORSTEP. Also, we made visits to a local traditional medicine market in Hyderabad and to Pastapur, where DDS has developed a herbal medicine garden and pharmacy.

Natural and Herbal Remedies for Common Problems

***NEEM* for Yeast Overgrowth & Trichomonas Infection in Vagina**

Other names for Neem:	Latin: Azadirachta Indica Telugu: Vepa Hindi: Neem
Part used:	fresh leaves
Properties and some of it's Uses:	Discourages microbes and worms (anti-helminthic); purifies blood; anti-diabetic; womb tonic.
Preparation of Tampon:	Wash 8 to 10 leaves & grind to paste. Roll into finger-like shape in a fine clean cloth strip, & tie with thread.
Use:	Insert all the way up into the vagina. Repeat morning and night for 10 days.
Also... Neem Water & Paste	Luke-warm wash, or soak in sit-bath, with water of boiled neem leaves. Men should wash/soak and apply neem paste under the foreskin.

FRESH MILK-CURDS
for Vaginal Yeast Overgrowth

Other names for Curds (or Yoghurt):	Latin: microbe in curds is *Lacto-bacillus acidophilus* Telugu: *Peregu* Hindi: *Dahi*
Properties of Fresh Milk-Curds:	Cooling, mildly acidic; Lacto-bacteria challenge other microbes.
Use - Insertion into Vagina:	Take 2 spoons & smear inside with finger or clean cloth-piece, once or twice a day until problem clears up.
Also... if condition severe, long-standing:	First, wash inside of vagina with 2 spoons of *vinegar* in a mug-full of water twice a day, for 10 days.

***INDIAN ALOE* for Painful Menstrual Cramps**

Other names for Aloe:	Latin: *Aloe barbadensis* Telugu: *Kalabandha* Hindi: *Kunvar, Kumari*
Part used:	leaf pulp (jelly-like)
Properties:	nutritive, astringent, stimulates liver functions.
Preparation of Paste: (3 doses)	Cut & wash leaf, remove about 100 grams of pulp. Mash and mix with 10 gms. of crushed rock-sugar into jelly-like paste.
Use:	From first day of periods, take 1 spoon (1/3) once a day for 3 days, for 3 cycles

FENUGREEK for Painful Menstrual Cramps

Other names for Fenugreek:	Latin: *Trigonella fenugrecum* Telugu: *Menthulu* Hindu: *Methi*
Part used:	Seeds
Properties:	De-congestant, carminative, astringent, anti-inflammatory, diuretic, nutritive tonic.
Preparation of Paste:	Grind seeds to powder. Mix with twice as much *ghee*.
Use:	Before meals twice a day, stir 2 spoons into a cup of milk, take everyday for 3 cycles.

GARLIC
for Vaginal Trichomonas Infection

Other names for Garlic:	Latin: *Allium sativum* Telugu: *Velluli* Hindi: *Lasun*
Part used:	Bulb (consisting of cloves)
Properties of Garlic:	Stimulant, nutritive, carminative, anti-spasmodic, and anti-septic
Preparation:	Peel a clove of garlic without nicking it.
Use: Insertion into Vagina	Insert high up; keep inside overnight only, or change twice a day, 10 -15 days.
Also...	Eat a clove of garlic daily. This is for men, too.

COUNTRY MALLOW
for Painful Menstrual Cramps

Other names for Country Mallow:	Latin: *Abultilon Indicum* Telugu: *Sannapukayala, Tutrichettu* Hindi: *Kanghani*
Parts used:	Leaves, dried in shade
Properties:	Decongestant, diuretic, laxative and sedative
Preparation of *churna*: (2 doses)	Mix and crush 20 grams of dry leaves, 5 grams of *cumin* seeds and 10 cloves of *garlic* into a dry powder.
Use:	On first day of periods, take 1 spoon of powder, morning & night. Continue, 3 cycles.

HENNA
for Heavy Bleeding during Periods

Other names for Henna:	Botanical: *Lawsonia inermis* Telugu: *Maidhakku*, Hindi: *Mehendi*
Part used:	Leaves, fresh
Properties:	Astringent, deodorant, detergent
Preparation of Juice:	Take a handful of leaves, grind to a paste & press it through a clean cloth-piece.
Use,	During periods for 3 days, take 2 spoons before food twice a day, for 3 cycles.

WHITE SHOE-FLOWER
for Painful Menstrual Cramps

Other names for white shoe-flower:	Latin: *Hibiscus rosasinensis* Telugu: *Jara Pushpamma* Hindi: *Safed Jasund*
Parts used:	Flowers, leaves, and stem.
Properties of flowers & leaves:	F: cooling, anti-inflammatory L: anti-inflammatory, laxative, estrogen-like.
Preparation of Paste: (3 doses)	Take 4 inches of stem, a flower, a handful of leaves, and 2 tsp. of cumin seeds; grind to a smooth paste.
Use:	Before food, mix 1/3 in a cup of milk, take 3 times on first day of periods, for 3 cycles.

TOUCH-ME-NOT
for Painful Menstrual Cramp
& for Heavy Bleeding

Other names for Touch-Me-Not:	Botanical: *Mimosa pudica* Telugu: *Athi-pathi, Lajalu* Hindi: *Lajwanti, Chhui-muhi*
Parts used:	entire plant including roots
Properties of Roots and Leaves:	R: resolvent, nutritive & carminative L: anti-septic, blood purifier
Preparation of Powder, & Decoction: (1 dose)	Wash & dry plant in shade, then powder it. Take 1 spoon (5 gr) in 3 glassfuls water; boil down to1/3.
Use:	Drink 1 glass every morning for 7 days during periods, for 3 cycles.

GUDUCHI
for Heavy Bleeding during Periods

Other names for Guduchi:	Latin: *Tinospora Cordifolia* Telugu: *Thippatiga* Hindi: *Gulancha, Gurubel*
Parts used:	Leaves, stem and root
Properties:	Nutritive, diuretic, hormone balancing, digestive.
Preparation of Decoction: (1 dose)	Take 5 grams of leaves or stem in 3 glasses of water, boil down to 1/3.
Use:	During periods, drink a glass daily, upto a week.

FLAME OF THE FOREST

for Strengthening Womb & Pelvic Parts & Relieving Menstrual Cramps from Fibroids & Endometriosis

Other names for Flame of the Forest:	Latin: *Butea monosperma* Telugu: *Moduga* Hindi: *Dhak*, Palash
Part used:	Inner bark
Properties:	Astringent, diuretic, tonic, progestrone-like effects
Preparation of Decoction: (1 dose)	Take a piece (10 g) of bark in 3 cups of water, boil this down to 1/3 decoction.
Use:	After periods, for 3 weeks of cycle, 1 cup in morning on empty stomach, for 3 cycles

BABUL for Strenghtening Pelvic Parts, Womb

Other names for Acacia:	Latin: Acacia arabica Telugu: Nallathumba Hindi: Babul
Part used:	Bark
Properties:	Astringent, ...
Preparation of Decoction:	Take a 2-inch piece of bark, boil in 3 glasses of water, down to 1/3.
Use:	Take one glass every morning for 3 months

FENNEL, OR CUMIN
for Urinary Infections

Other names:	for Fennel - Telugu: *Sopu* Hindi: *Saunf*	for Cumin - *Jeerakam* *Jeera*
Part used:	Seeds	
Properties:	cooling & helps freely pass urine	
Preparation of decoction:	Add 3 spoons of fennel/cumin seeds in 3 glasses of water; boil down to 1/3.	
Use:	Drink half a glass 3 times a day, and continue for a week or more.	
Also...	Drink plenty of water and fluids. Eat 3 raw green lady-fingers on an empty stomach daily.	

A Dream of Women's Resource Centres

We asked the group, *What do you remember of these last six days?*

We wrote down our life-stories, looked at ourselves, did our self-exams... talked about things we've never shared with anyone!

We listened and didn't laugh. We weren't shocked... We didn't blame.

We were comfortable, and relaxed. Our space was our own.

Like friends looking at each other - we knew what was happening. We were in control.

There was no doctor, or table to jump up onto... No lifting and opening legs for someone else, not knowing what was next.. No fear!

I was astonished to see inside with the mirror and speculum. I want all women to have this thrill!

Yes, it was like this, because we had a *safe* space of our own. At the pre-training meeting with project partners and staff, we had spoken of our idea of Women's Resource Centres. Now, all of us together could start to visualise them.

Our centre must be open when women can come - before work in the mornings and in the evenings.

It must be a place easy to reach, and welcoming.

We can make it beautiful.... Decorate it with our culture, our art, our charts and survey findings.

It will have place for a herbal garden, and let women grow and exchange the herbs they need.

Our centre will throb with life!

Gyn-Ecological Disorders and Healing

Objectives

- to understand the range and nature of disorders in women's bodies
- to appreciate the difference between a *gyn-ecological approach* and *gynaecology*
- to use self-help knowledge and skills for seeing and healing gyn-ecological disorders
- to encourage women's traditional healing knowledge and practice
- to demand and make use of necessary medical tests and services from the public health system

Methodology

Life-Story Taking and Self-Exams:	of local women participants
'Live Visuals':	infected secretions (STIs, RTIs) disorders of vagina and cervix; womb descent cervix/vulva/abdomen scars
Healing Practices:	foods with certain effects herbal remedies massage and exercises
Counselling and Net-Working:	exploring roles as friend, women's advocate, and activist for change

Deeper into the Region of Silence

In the previous sections of our self-help journey, we discovered and travelled through areas of silence to reclaim our bodies and their natural powers. In this section we enter deeper into a region where everything is hushed. We found that all along women have been coping with ailments, healing themselves and others, using remedies passed down by their fore-mothers.

Problems We Found in Our Self-Help Group: This is a summary of what we found during the self-exams in our group, described in the last section. Between us eighteen women,

7 women had inflamed vaginal walls
5 also had infected secretions
2 had PID (pelvic inflammatory disorder)
3 had angry-looking cervical erosion
2 had mild descent of their wombs
1 had a very small womb,
2 had hyper-acidity, and
9 had anaemia, 7 moderate and 2 severe.

Elsewhere: There is *scant information* about what diseases women suffer from, and how many women suffer from them. Especially in our country, where society keeps it secret. But, a community-based gynaecological study in eastern Maharashtra (Dr. Rani Bang, Lancet, 1989) found that 92% of women had sexual and reproductive tract diseases. Half of this was due to infections. Only 8% of the women had got medical care.

Earlier, we gathered from government statistical figures that only 13 percent of deaths in women are because of reasons related to pregnancy and childbirth. The rest (87%) are deaths caused by other factors. Yet, so little thought is given to meet the general health needs of women.

Changing the Scene - Women in Rapur

While doing the health-status survey in Rapur, women had told our participants that they had many ailments, especially 'white discharge', and they asked for help. Hence, we decided to do this session at SPEAK INDIA. This would give the participants experience of taking life-stories, seeing the various gyn-ecological disorders of women, using herbal remedies, and working out practical ways to tackle the problems along with the other women. Subbamma, Lakshmi Narsamma and Navneetha had invited local women to come and share their problems. Most of the people of this area belonged to the *enadi* tribe.

We looked forward to learning about the gyn-ecological conditions which we have seen causing women a lot of suffering. From the earlier sessions, we understood much about our own bodies, and how they work. Now, we would be able *to use the skills* which we had learned. We were keen to apply traditional local knowledge within the framework of a new gyn-ecological understanding.

Gynaecology and Gyn-Ecology

Earlier, when we focused on the Politics of Health and Population, we looked at the dominant trend of *'medicalisation' of health.* Now, we took some time to look at doctors' practice of 'gynaecology' to see how it medicalises women's natural functions. Doctors when treating 'gynaecological diseases', also use medicines and technology to alter natural female processes. We discussed various abuses of hormones, amniocentesis and ultrasound, surgery, and so on. 'Treatments' suppress 'symptoms' without identifying or helping women to deal with the causes of disorder. Where a majority of women are anaemic, underfed and over-worked, the consequences of such treatments may turn into silent disasters.

But, not only doctors, even *vaidyas* and homeopaths appear to have a slanted view towards what they group together as *'stri-roga'* or 'women's conditions'. Whether seen through any of these physicians' spectacles, women's health is socially constructed around patriarchy's idea of a woman's womb. Even the 'mental' condition called 'hysteria' derives from an old idea that a woman's womb goes wandering where it shouldn't (*hysterus* = womb or uterus in *Latin*). All other conditions of ill-health in women which do not relate to the womb and its functions are lumped under 'diseases' as they affect males.

Gynaecology (as part of modern medicine) sees ill-health through a few simplified, mechanistic reductions. Basically, it tells us that 'diseases' result from either

⇒ *germs* which 'invade' the body, or

⇒ fluctuating and un-controlled *female hormones.*

An extension of the second belief is that all of women's sexual and reproductive functions are not really normal

- menstruation, sexuality, fertility and infertility, pregnancy, childbirth, lactation, and menopause -

and should be regulated by medicines or removed by surgery. Gynaecology denies our body's basic capacity to keep or regain it's balance.

With our new view of *health* as a dynamic state of balance including our whole inner and outer environment, we look at *gyn-ecological disorders* much differently.

Disorder in Women's Health

The social and physical environment around women is drastically out of balance. A woman does not get enough food, nor clean water and air, she is over-worked, she lacks rest and shelter, she has no control over her fertility and sexuality, and she stands unrelenting emotional stress from neglect, discrimination and violence. To some extent, her body is able to cope with external imbalances, but gradually her natural ability to heal herself gets eroded, and the following happens -

⇒ her body tissues fail to *rebuild* themselves,

⇒ her *resistance* to infections breaks down,

⇒ her natural hormonal *rhythms* get distorted,

⇒ her emotions and mind fail to *respond* to her needs, and

⇒ in her *relationships* with others she becomes powerless and loses creativity.

She gets anaemia, her bones dissolve, and her womb descends. The weakened body cells no longer prevent harmful over-growth and spread of microbes in her body, so she is open to infections like STIs, TB, and so on. Stress on her neuro-hormonal system may cause partial or total shut-down of fertility and sexuality and other glandular functions. These show up as menstrual problems, hyperacidity, diabetes, arthritis, and so on - even childlessness. She cannot think straight, least of all how to help herself. She becomes anxious and depressed, and may lose her will to live.

Gyn-Ecological Self-Help with Village Women

It was August, and it had rained heavily the night before. Only sixteen women could reach the centre. Several of them had to walk for hours. They joined us as new participants - not 'patients' or 'cases'. They stayed with us for two days. First, in the whole group, they gave an idea of their problems. Then, they dispersed into two's and three's, and a detailed life-story of each woman was taken. The women participated in all the activities and discussions that followed. Each experienced the life-story-taking, self-exam and healing process individually, but here, we have grouped women who had similar problems.

The following are sketches from the life-stories of three women who had *yeast disorder*:

Venkatamma is a landless labourer. She earns just Rs.10/- a day doing coolie work. She is about thirty and she has four living children. Her husband doesn't add to the daily earnings, as he spends it all on alcohol. Nearly every night, he beats her and then he forces sex on her. She is severely anaemic. Her diet consists mainly of rice and chillies - vegetables are rare and a luxury. Venkatamma's life is nothing but violence and hardship.

Shailaja is thirty-four. She has five children and lives with her husband and his new second wife in Rapur town. Whatever she earns from coolie work isn't enough to feed her children and herself. She is mentally tortured and physically strained to her limit. She looks emaciated and depressed.

Pappama is a widow of about thirty-two who lives alone. She makes stick brooms. She has been suffering from tuberculosis for the last two years. She takes medicines, but has not been regular about it. Whenever she feels well enough, she walks from one village to another selling her brooms.

Each of these women felt low back pain and joint pains with severe itching in her vulva, and burning, and had thick white vaginal secretions. We discussed what these symptoms could mean. After the whole body exam, then came the self-exam with speculum. The women were shown and explained the speculum. Since they were nervous and shy about their lower parts, one of us volunteered to do a speculum exam on herself. Seeing this, they got the courage to do the exam on themselves. All three women were able to see their vulvas and what their vaginas looked like

inside. We urged them to describe what they saw, and to smell the secretions on the blade of the speculum.

This is what they observed:

- redness and a rash on the vulva
- bright red swollen vaginal walls
- white patches on the vaginal walls and cervix
- thick white curd-like secretions, with a 'smell of yeast'

Before naming this condition, we explained to the women about normal and infected secretions, and about the ecology of the vagina. Itching and burning in the vulva, unpleasant odour, excessive and off-coloured secretions are signs of disorder in vaginal ecology.

We recalled what all of us had seen. We explained that Venkatamma, Shailaja and Pappama had a *yeast overgrowth*.

Infections and Inflammation

Infection is the harmful overgrowth of natural *microbes*, or the entrance and spread of certain harmful microbes, leading to disorder in our body. Various kinds of microbes result in infections, like 'bacteria', 'yeast', 'trichomonas', 'amoebas' and 'viruses'.

Inflammation is our body's local response to injury of tissues and cells because of infection, a physical wound or a chemical substance. This response includes blood filling to the tiny blood-vessel net-works and migration of white blood cells into the injured area. Because of this, there is usually

heat and redness,
swelling and pain, and
excess secretions.

Inflammation is the way our body locally tries to gain control over troublesome microbes or irritants.

Yeast Infection of the Vagina: Doctors call this *monilia* or *candida* infection. Yeast is not an 'infection' in the sense doctors mean - it is an *overgrowth* of a fungus-like microbe that naturally lives in our mouth and our moist vaginal and anal passages.

Both yeast and harmless *lacto-bacillus* normally live in balance in the vagina. Anti-biotics kill off the bacteria and cause an over-growth of yeast. Yeast problems also crop up in pregnancy, in diabetes and in times of prolonged stress, and because of steroids and hormonal contra-ceptives. In each of these conditions, *sugar* increases in our blood and vaginal cells, and feeds the yeast.

Sometimes, we see yeast overgrowth in the mouth (also called *thrush*) in children, sick and old people.

Remedies for Yeast Infection: Natural remedies are better with yeast infections than anti-fungal tablets and creams which doctors prescribe.

⇒ Women find that yeast problems clear up with *fresh milk-curds* put into the vagina. Milk-curds contain lacto-bacillus, and the curds are mildly acidic. Yeast microbes reduce their numbers and the vaginal ecology gets restored.

⇒ If severe or long-standing, it may help to first wash the vagina inside with a dilute solution of *vinegar* and water.

⇒ Garlic is also effective. We all practised peeling a garlic clove without nicking, and inserting it high up in the vagina.

⇒ An old-fashioned but effective allopathic measure is to swab the vagina with *gentian violet*.

Until full recovery, other advices are:

- avoid penetrative intercourse, and
- eat enough cooling foods.

The problem with advices like these is that having sex and food are not in women's control.

Sexually Transmitted Infections (STIs): We listened to life stories of some more women. These are two sketches.

Parvathamma is starved and has severe anaemia. Her pale, puffy face suggests she also has hookworms. She is lethargic and looks exhausted. She has been married for sixteen years. Now at the age of twenty-eight, having lost three children, she has five left. Her husband is a rickshaw puller in town. He has been having sex with other women. Parvathamma barely manages to go for coolie work once in a while.

Sukamma is thirty and has three children. She is thin and anaemic, and she does not want to have more children. Her husband has refused to allow her to have a tubectomy. In the last two years she has had three abortions done, all in the village. Her last was when she was six months pregnant. She suffered much pain and got a bad infection. Now she has severe low back pain and heavy, thick discharge with a foul smell.

Parvathamma, Sukamma, Mallamma, and Rukmini said they had severe lower back pain and heavy 'white discharge'. It had soaked and matted their thin saris. They also had severe itching and burning when they passed urine.

This time the women readily did speculum self-exams. They found -

- vulva painful, itchy, swollen
- vaginal walls red and swollen, with small red spots and patches also on cervix
- greenish yellow frothy secretions, and
- a peculiar foul and fishy smell.

Vaginal Trichomonas Infection*: Trichomonas* are tiny one-celled microbes with a whip-like tail with which they move about in the vagina.

They normally live in our bowel and also in our vagina without causing any problem. It becomes a problem when they over-grow or get introduced in large numbers through sexual contact. Wet or synthetic under-wear make things worse. Washing and wiping from back to front after defecation, or anal intercourse followed by vaginal penetration, can introduce trichomonas.

If uncontrolled, trichomonas can move up through the womb and egg-tubes and cause pelvic inflammatory disorder (PID).

The following remedies are helpful in trichomonas conditions:

⇒ a sit-bath and wash with luke-warm **neem water**; men can do this, too.

⇒ a **neem tampon** in the vagina, changed morning and night, for ten days.

⇒ for men, direct application of **neem paste** below the foreskin of the penis.

⇒ where neem is not available, a **garlic** clove can substitute for the tampon.

⇒ a clove of **garlic** eaten daily, by both partners.

A trichomonas problem usually comes through sexual contact with an infected partner, so it is important to heal him as well. He should use a condom during intercourse, or avoid penetrative sex for at least three weeks to allow the woman to heal completely. We suggested that Parvathamma get a stool exam done (for hook worms) and we discussed anaemia in general.

Syphilis Infection: Kamala was reluctant to talk. She had just 'come along' with the others.

She was about twenty-four, and married for five years. Her husband was a truck driver, and they were childless. She had left-over scars from a rash on her body. She felt burning while passing urine.

After much coaxing Kamala came forward to do self-exam. She showed her vulva and we saw a large ulcer.

I've hidden it from others - I was afraid. It dried up once. Now it's come again.

Through the speculum we all could see similar smaller ulcers on her vaginal walls. We explained to Kamala that it could be serious, even though the ulcers were not painful. Tears started flowing.

I want a child badly. My husband comes home rarely. I know he's having sex with other women. I've seen sores on his penis, too.

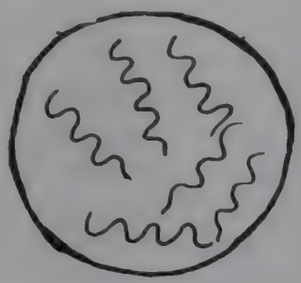
We talked with Kamala about how to get her husband to go with her to a Government hospital. They must both get their blood tested for STIs

(VDRL Test) and take a full course of penicillin injections. She would have to insist on him wearing a condom during sex. Kamala replied,

If I ask him all this, he won't stay with me - he'll stay away longer!

Lakshmi Narsamma said she would go and reason with him.

Syphilis is a very serious 'sexually transmitted infection' (STI). If unhealed, it may last in the body for many years and cause a lot of damage.



Tiny screw-shaped *syphilis bacteria*, called *spirochaetes,* live in the warm, moist linings of the genital passages, the rectum and the mouth, and in the sores. But, being very sensitive to dry air, they die immediately once outside the body.

If a pregnant woman is infected, she may pass on the infection to the foetus in her womb.

The signs of syphilis depend on the time since the infection began:

⇒ *within days* - a painless sore, on penis, vulva, vagina, cervix or mouth; it does not bleed, but secretes a clear fluid with microbes;

⇒ *within weeks or months* - a rash (copper-coloured) and sores over the body, enlarged lymph glands, enlarged liver and spleen;

A woman can have miscarriages, still-births, or children with congenital syphilis.

⇒ *ten to thirty years later* - breakdown in skin, joints, heart and large blood vessels, nerves and brain

We don't know of a complete herbal remedy for syphilis. In view of long-term risks, both partners must get standard anti-biotic treatment. Long-standing syphilis requires repeat treatment. You must find a good, friendly doctor in your area where you can refer couples for a *VDRL test* and proper treatment.

Gonorrhoea Infection: Some women whom we saw with heavy infected secretions were likely to have gonorrhoea, another STI which women get from infected male partners.

Gonorrhoea bacteria, called *gono-cocci*, thrive in the warm, moist lining of the urine tube, vagina and rectum, and also can live in one's mouth and throat, or one's eyes - all mucus membrane surfaces. It is normally passed by direct sexual contact. During child-birth, a woman's vaginal secretions can infect her baby's eyes with gonorrhoea, causing severe eye inflammation resulting in *blindness*.

The signs of gonorrhoea are different for men and women:

In men there is usually *pus from the penis*, and *burning* at urination. Later it leads to retention of urine and joint pain and swelling.

Most women *at first have no symptoms or only mild symptoms* like discomfort while passing urine, itching in the vulva and vaginal secretions. If not treated, gonorrhoea infection may spread, with

- burning and pain up the urinary passage,
- painful swelling in a vulvo-vaginal gland,
- swelling and pain in the rectum,
- inflammation of cervix and womb, with secretions,
- swelling and obstruction in the egg-tubes.

Such extensive infection and inflammation can result in fever, abdominal pain, backache, painful or excessive periods and painful intercourse. If the infection finally burns itself out, or even if complete treatment is taken at this stage, *sterility* results from blockage of the egg-tubes. Gonorrhoea may spread through the blood and to the bone joints, causing gonorrhoeal arthritis.

Because the early signs in men are more noticeable, and since men have more access to health services than women, they tend to go and get treatment early.

With a speculum, you may see thick, pus-like secretions coming from the cervix, redness and small bumps and signs of erosion on the cervix.

A smear of the secretions to find gono-cocci may be taken, but testing is not necessary to start treatment. The healing must include a full course of standard anti-biotics like penicillin or tetracycline, as in syphilis. Herbal remedies are supportive only.

Infection with gonorrhoea is often mixed with syphilis. Many women infected with gonorrhoea have trichomonas infection, too.

More STIs: There are other STIs - *genital herpes*, *genital warts*, *chlamydia* and more - about which we still need to learn. *'AIDS'* is also an STI, and later on we give special attention to it.

How can we Protect Ourselves from Getting STIs

Lack of control over sex and fertility puts women at high risk of getting STIs. If a woman discovers she has one, she keeps it hidden and suffers the effects in isolation.

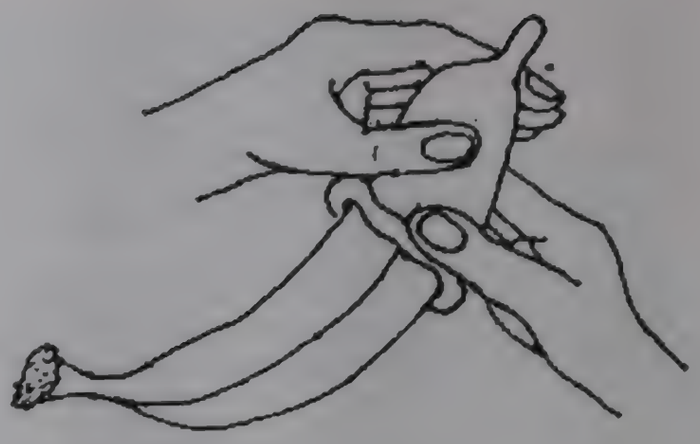
Last month, one of us had severe itching and burning in her vulva. When she did her speculum self-exam, she found lots of frothy, yellow-brownish smelly secretions flowing from her cervix. She told us,

I must have got this from my husband, but...He's a very nice man....he doesn't go to any other women... .I don't know how he got this. But, he does have sores on his lingam. Every time we relate, I get terrible pain and burning.

It would be of no use if only she gets treatment - *both* must have it. For some time they would have to avoid genital contact. If he insists on penetration, he must use a condom. She was sure he would agree. Now, she said,

Akka, he's been following the advice and not insisting. He wants me to get well. He doesn't know how to use the condom, and asked me to find out from you.

We weren't surprised that a man was asking to know about condoms. During *jatras* in Medak District, some men told us a condom was supposed to be used by unrolling it over one's thumb... Others attempted to put it on before getting an erection. To see how to put a condom onto an erect penis, each participant was given a condom and a raw green banana.



Certain practices are *unsafe*, like

penis-to-vagina sex *without a condom,*
mouth-to-penis or mouth-to-vulva sex,
penis-to-anus sex *without a condom, and*
any penis-to-vagina sex *after anal sex.*

We can make the risks less by

⇒ knowing the sex-habits of your partner, checking him and yourself for sores and secretions, and getting complete treatment,

⇒ using 'safer sex practices', and a condom during intercourse.

⇒ washing the genitals and passing urine before and after sex, and men cleaning carefully under the foreskin.

Safer Sex Practices for Women: The point of 'safer sex' is not to give up pleasure - it is to find ways of 'pleasuring' ourselves and our partner that put both of us at less or no risk of getting any kind of STI, including HIV infection.

We thought of many *safer sex options*, like massages, rubbing and fondling, stimulating the clitoris and penis by hand or in other ways, touching and hugging, kissing, and more...there's lots of scope for creativity.

We must create spaces where women and men can talk without fear, and encourage sex education in schools.

Nageshwari has started sex education with girls and boys from two municipal high schools in Thumapalla town. Teen-aged girls visit the women's centre to talk and to do their self-exam and get advice.

Pelvic Inflammatory Disorder (PID)

After several abortions, Sukamma had severe low backache, pain in her lower belly and 'white discharge'.

Susheela had a low backache which started after her tubectomy.

Aruna had got a copper-T inserted a few months before. She had severe pain in her lower belly, thick, foul-smelling secretions and pain during intercourse.

We did whole body, belly and bi-manual exams with Sukamma, Susheela and Aruna. Each did her own self-exam, too.

While we felt the lower belly, we pressed over some swelling inside, and they felt *pain*. During the speculum exam, we saw redness, swelling and thick infected secretions from the cervix. We could barely do bi-manual exam, as it was painful for them - we felt swelling around the womb and egg-tubes.

These are signs telling of 'pelvic inflammatory disorder', or PID. While the signs in each woman were similar, the reasons were different.

In PID, the inflammation (swelling reaction) usually results from infection by microbes which get into the pelvic space in some way or other. The various sites which get involved are the pelvic tissues, the ovaries, the tubes, the womb lining, and the inside of the cervix. The picture of a woman with PID shows an infected site in the egg-tubes and ovary of one side compared to the other normal side.

Infection enters through sexual contact, or is introduced during abortions, complicated childbirths, or IUD insertion (like copper-T) and tubectomy operation. Another cause for PID is TB where the infection reaches the womb and other structures through a woman's bloodstream. It silently destroys the womb lining and blocks the tubes.

PID leads to many different signs, including:

chronic low abdominal pain, low backache ,
burning while passing urine, urine retention,
vaginal secretions with foul smell, itching,
painful ovulation; painful heavy periods,
pain and bleeding with or after intercourse;
sterility, ectopic pregnancy, early miscarriage.

Healing of PID: according to the causes,

⇒ STIs are treated as described above

⇒ For TB, see the topic later on in this section.

⇒ If you have complications from an IUD,

- first, have the IUD removed.
- then, take a full course of *anti-biotics*.
- you can take herbal remedies to relieve your pain and heavy bleeding and to strengthen your pelvic tissues and body.

While you take antibiotics, yeast overgrowth may crop up. So, at the same time, heal any yeast condition with milk-curds.

Pain During Menstrual Periods

Most women experience some pain during their menstrual periods, whether or not they have an inflammatory condition in the pelvis. These we call 'ordinary menstrual cramps'!

Some women have much more pain. During our session at Rapur, Nageshwari told us she was having severe low back-ache with her periods. She wasn't able to concentrate or even sit through the sessions. Nageshwari already suffers from back problems, and the pain gets worse during her periods. She also has a strenuous work schedule riding her luna, she doesn't eat enough, and she copes with stress in family and work-place.

For her severe menstrual pain, Pushpa gave her *athi-pathi kashayam* (decoction of *'touch-me-not'*). She was advised to take foods having calcium, as it is an important mineral for the bones and co-agulation of the blood. As there was plenty of drumstick leaves in Rapur, we included drumstick leaves, cabbage, carrots and *ragi* in our diet and gave her jaggery to eat.

We took this opportunity to explain what happens during menstrual cramps. We had learned about the changes that happen during the 'fertility cycle'. Just before menstruation, estrogen and pro-gestrone hormone levels fall. The mucus loos-ens, and uterine contractions empty the uterine cavity in few days.

Pain may be due to the spasm of the cervix with retention of menstrual fluid inside the womb. Clots may form, which are painful to pass, too. If there is infection and inflammation in and around the womb, a womb contraction is more painful.

As we learned from each-other in our self-help session, there are a number of remedies for painful menstrual cramps. Relaxation and yogic exercises, particularly the *cobra and bow asanas*, *massage of the lower back and of the womb* through one's lower belly and *pressing behind the ankle* tendon (polarity massage) are some of the measures women have found to get relief.

Herbal Remedies made from country mallow, aloe, white show-flower, methi and touch-me-not may be helpful. We have collected these recipes in our self-help section.

There are other problems a woman may experi-ence with her menstrual periods: pre-menstrual discomfort, irregularity, absence of period and heavy periods.

We discussed menstrual hygiene at length. We can get an infection if the menstrual cloths we use are unclean, over-used or not changed often enough. We decided all of us would wash and boil the cloths, and dry them out in the sun after each period.

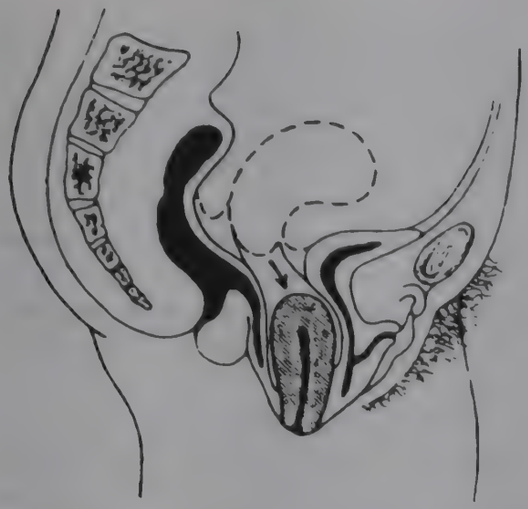
Now we've learned the menstrual secretions are not 'polluting', let's not fear drying them in open daylight!

Heavy Bleeding during Our Periods

The problem of heavy bleeding was familiar to most of us. We shared our experiences of how many times we changed our menstrual cloth in a day, and the number of days of bleeding in a month. Women said that if there is more heat in our body, it will cause menstrual discomfort and excessive bleeding. Our women's diet consisted of tamarind and chillies, both hot foods. Most of our women were undernourished and worked un-der much stress.

There are many reasons for heavy bleeding dur-ing periods - severe anaemia, hormonal imbal-ance, stress, PID, fibroids, and hormonal contra-ceptive methods.

The herbal remedies which we used are made from *henna*, *touch-me-not*, and *guduchi*.



Descent of Womb and Bladder

The month before, our participants Nageshwari and Pushpa had discovered through their self-exams that they both have mild *womb descent*. Narsamma, one of the women at Rapur showed us that her womb had come down between her thighs. She was around fifty. It bothered her a lot while walking and working. During sex, she first would have to push it inside.

The muscles which make up the pelvic floor support the womb, bladder and rectum. These structures become weak from over-work and less food, plus the strain of child-bearing and difficult and neglected child-births. The bladder tends to come down along with the womb.

Mild to moderate womb descent causes symptoms like frequently passing urine, infected vaginal secretions and low back-ache. In *moderate* womb descent, if a woman squats and coughs, or if she strains and bears down, her cervix comes through her vagina, and then goes back in. If *severe*, she must replace her womb by hand like Narsamma, but it keeps coming out.

Improvement in the *food* situation is important. Severe womb descent may need *surgery*. Nageshwari and Pushpa were already doing *exercises* to strengthen their pelvic floor muscles. They taught the group these exercises, and how to make an herbal decoction of *babul bark* or *flame-of-the-forest bark*. One needs to have patience with womb descent - care and time will bring as much healing as possible.

Navneetha said she would talk to Narsamma's husband for him to understand her discomfort during sexual intercourse, and she would accompany her to the government hospital for a surgical operation.

Urinary Infection

A common sign of having a urinary infection is passing urine often, accompanied by burning and pain. The urine may be cloudy, sour-smelling and may contain blood. One may have backache, pain in the lower belly over the bladder, fever and chills. Sometimes, it may be related with a vaginal infection.

There are various reasons why women are more prone to urinary tract infections and inflammation of the bladder than men.

- The female urine passage is shorter, easy for microbes to reach from anus and vagina.
- Women can't find places to urinate so easily, and so they drink less liquid.
- Scarcity of water makes it difficult to stay clean, especially during periods.
- Intercourse may irritate the urinary passage.

The commonest microbes in urinary infections are called *E. coli*, and they are usually found in the large intestine and rectum. Sometimes they get into the vagina or urinary passage. If the ecology is disordered, they grow quickly as the protective secretions in the vagina are changed. Yeast overgrowth may encourage *E. coli*. *Gono-cocci* and other microbes get involved in urinary infections, too.

In older women, lowering in hormone levels makes the vaginal and urine tube linings thinner, sometimes increasing the chance of developing infections. Emotional stress and diabetes can also contribute to getting urinary infections.

We can help *prevent* urinary infections by

⇒ drinking a lot of water and other liquids,

⇒ not holding back urine long when one needs to urinate,

⇒ after passing stools, cleaning front to back,

⇒ using clean menstrual cloths, change often.

⇒ and protecting ourselves from STIs.

Along with these precautions, there are some helpful remedies for healing urinary infections like Fennel or Cumin Decoction.

Raw *lady's finger* (Telugu: *bhindikai,* Hindi: *bhendi*) has a similar cooling and diuretic effect as fennel and cumin. You may eat three fresh lady-fingers on an empty stomach every morning for a week.

Anaemia in Women

The complex of malnutrition-and-anaemia is the biggest under-lying cause of ill-health and deaths in women. Anaemia means that *our blood is thinned out*. It lacks so many things that healthy blood should have, like iron, oxygen, red and white blood cells, immune factors, clotting factors and so on. Especially *haemoglobin*, the red coloured iron-binding, oxygen-carrying substance in our blood cells, gets drastically lowered.

The many disorders linked with anaemia arise from *basic factors*, like subtle and overt violence and discrimination, environmental degradation, changes in cropping patterns, rising prices, poor sanitation, unavailable health services and so on. The *immediate factors* is a poor diet especially in iron and protein, hook-worm and other infestations, bleeding from menstrual disorders, STIs and other infections, repeated child-bearing in already weakened condition, unsafe and repeated abortions, and complications of long-acting invasive contra-ceptive methods. When one's blood is thin as in anaemia, it does not clot as it should. So, *anaemia itself makes women bleed more,* as in a vicious cycle.

Signs of anaemia are very pale skin and paleness of membranes inside the eye, mouth, vulva and vagina, puffiness of face, swelling of feet and legs, tiredness, dizziness, headache. There may be burning pain in upper belly due to our weak stomach membrane reacting to natural acidity. Also, one can feel a fast, pulse because the heart gets over-worked.

Much of anaemia can be prevented or healed by having enough *food.* Foods containing iron, vitamins and protein like *greens, ragi, dals* and *jaggery* are good. But getting proper food to eat is uncertain considering women's low social status. The government scheme to distribute iron-and-folic-acid tablets to pregnant and breast-feeding mothers is hardly enough to tackle the problem.

Tuberculosis (TB)

TB, which is also called *Koch's*, is an infective disorder which also arises out of poverty, malnutrition and social injustice. It involves an infection with *Myco-bacteria tuberculi* microbes which most commonly affect the lungs. TB spreads in poor people's bodies because of lack of food and low body resistance, and because of unventilated and cramped living spaces. Tiny myco-bacteria are coughed out into the air, and infect others nearby, especially children, weakened adults and old people. TB of the lungs is the commonest form. Besides, it may affect other parts of our body - like TB of lymph glands, intestines, skin, bone and brain. Women can get TB in the womb and egg-tubes. Genital TB is one of the big, silent causes of childlessness.

Most of us have some TB bacteria inside us. But, our bodies do a lot to resist their growth, and most of us do not get sick with TB. If we are sick, however, doctors often mistake the symptoms and signs of TB for other conditions. So, we don't get proper or complete treatment early. Having TB is still a social stigma in most places, so people try to hide it.

Important symptoms of TB are:

- cough with sputum, for more than 15 days
- low-grade rise of temperature and night sweating
- pain in one's chest on one or both sides, and
- coughing up blood with sputum.

There may also be a *typical* wasted appearance of one's face and body, matted lymph glands in one's armpits, and swollen but cold and painless glands in neck and groin.

Doctors usually miss TB at first, so they give us cough mixtures and tonics, and sometimes they send us for un-needed tests. When they find someone has TB, they never tell us straight.

The simplest and cheapest test is a *sputum exam.* It shows myco-bacteria, which an X-ray cannot. It is one of the tests that must be guaranteed at a government PHC.

One needs to take *complete* treatment to overcome TB. We know of no other effective treatment besides a full course of allopathic anti-TB drugs. In addition, a woman needs enough food to keep up her strength - she should eat along with her family, and not last. Pregnancy should be avoided until after the treatment.

Health activists have been struggling to make people aware about the huge problem of TB and the need for complete and timely treatment. A new dimension is the *association of TB with AIDS*. The Government should be ensuring that anti-TB drugs are available. Yet, when we go to the PHCs, there is nothing...

AIDS is a Women's Issue, Too

Our session on AIDS focused on providing the right information and removing myths, and to look at measures to prevent the spread of HIV.

When asked what they knew about AIDS, some of our participants said they had heard that it is a dreadful disease for which there is no cure, more serious than cancer. Government posters inside the PHC building warn them about the danger of not using condoms, that it is a killer disease, implying that men get 'it' 'from' 'bad' women.

Myths about AIDS: There are many myths about aids that discriminate against women and which distort sexuality and relations between people.

Sex workers, drug addicts and gay men are 'high risk' groups.

If you are monogamous, you won't get AIDS.

If you use a condom, you can't get AIDS.

You can get AIDS by touching or being near an HIV-positive person.

If blood is donated by close relatives, it is safe.

AIDS patients are dangerous.

To target specific groups rather than *activities that are high risk* is misleading. It discriminates against people who are already denied civil rights and rejected by society. It gives others who are not targeted a certain complacency. When a woman who is not in prostitution finds she is infected, she is reluctant to talk about it for fear of being labelled a 'loose woman'.

Monogamy presumes the heterosexual *marital relationship* is a 'safe-sex' option, but it is imposed on women, and not on men. One may be monogamous with a partner who is infected, therefore it is incorrect to say that monogamous people are safe. The message of monogamy is moralistic, judgmental, and divides women into good and bad. A study in Mexico shows that women in prostitution make up less than one percent (0.8%) of HIV-infected people reported, whereas 'housewives' constitute an alarming nine percent!

One is not supposed to get infected with HIV if a condom is used. But given the poor quality of condoms, we cannot be so sure. Also, focusing on protection by condoms keeps it in people's minds that penetrative sex is *the* way to relate sexually. Sex is more than just intercourse, and other sexual activity is safe and pleasurable.

Blood donated by close relatives may be HIV-positive just like anyone else's, so the message that close family members' blood is uncontaminated is false.

The participants decided that *no group can be labelled as the cause* for spread of HIV infection. It has to do with the way people relate with each other, and with carelessness in sterilisation of needles and blood products.

The myths finally fizzled out when they found out what AIDS really is and how HIV is transmitted.

What is AIDS? AIDS is a mix of disorders which develop in a person *infected by HIV virus*. HIV enters into one's bloodstream, and sooner or later causes a break-down of the immune resistance in a person's body. HIV infection becomes AIDS after a time, depending on socio-economic and environmental conditions. Because of immune break-down, a person develops a number of problems like TB or pneumonia, loose motions from intestinal infections, and various cancers.

How does a person get HIV infection? The HIV virus can pass from one person to another in these ways:

- *unprotected* vaginal and anal intercourse with an HIV positive person
- transfusion of *infected* blood or blood products
- *unsterilised* injection syringes and needles
- infection from a pregnant woman to her foetus.

In India, the main way is through unprotected intercourse. If there are cuts or sores, the chances of HIV getting into the blood increases. HIV can be transmitted more easily by men to women, than by women to men.

Women are more at risk of getting HIV-infection and AIDS than men because

their general health status is poor

the vagina is a larger area for infection

the genitals of women are internal, and make it difficult to see the signs

penetrative sexual intercourse is over-emphasised

they get blood transfusions during complicated abortions and child-birth

they are prone to genital injuries from violent sex, unsafe abortions and child-birth

health services are not sensitive to women's needs, and

invasive hormonal and immunological contra-ceptives are forced on them.

Nowadays, health providers make ***blood testing*** *for HIV* compulsory for pre-natal and pre-surgical care. Many women come to know of their HIV status only at this crucial point, and as it involves a foetus, the woman's confidentiality gets violated.

Is AIDS Curable? There is not yet a 'cure' for AIDS. But, it is not invariably fatal. Many people have had it for a number of years. In fact, in our country they have built up an organisation called 'POSITIVE PEOPLE'.

More than three and a half million women are infected today, most in monogamous relationships within marriage. Most of them are of childbearing age, opening the way for direct transmission to the next generation. Yet, the government's AIDS prevention policies and programmes to check the spread of HIV infection do not address women, except those in prostitution. Information propagated by medical authorities has been warped and one-sided, creating fear among the people. They have failed in their duty towards HIV-positive persons, depriving them of their rights to treatment, rehabilitation and social integration.

The ***efforts by organised sex workers*** teach us a lot. In growing numbers, commercial sex-workers demand that their clients use condoms. They are becoming the best educators in prevention of the spread of HIV. They have pointed out that the groups labelled 'high risk' are in reality the most *at risk* and vulnerable. Also, that the largest number of persons involved in prostitution are men! In case her partner is HIV-infected and the condom breaks, the risk to a woman is thirty times more than to a man. Hence, they stress the need for supply of good quality condoms in women's interest.

How Can the Spread of HIV be Prevented? Aside from safer sex practices discussed earlier, we looked at ways we can protect ourselves and others from getting HIV infection.

⇒ See that needles and syringes are sterilised when receiving injections.

⇒ Check all blood and blood products for HIV infection before transfusion.

⇒ Have protected sex and explore safer forms of sexual activity.

⇒ Get early and complete treatment for STIs.

⇒ Assert ourselves, negotiate our sexual relations and resist violence.

After the session on AIDS, Sathyavati had an interesting encounter.

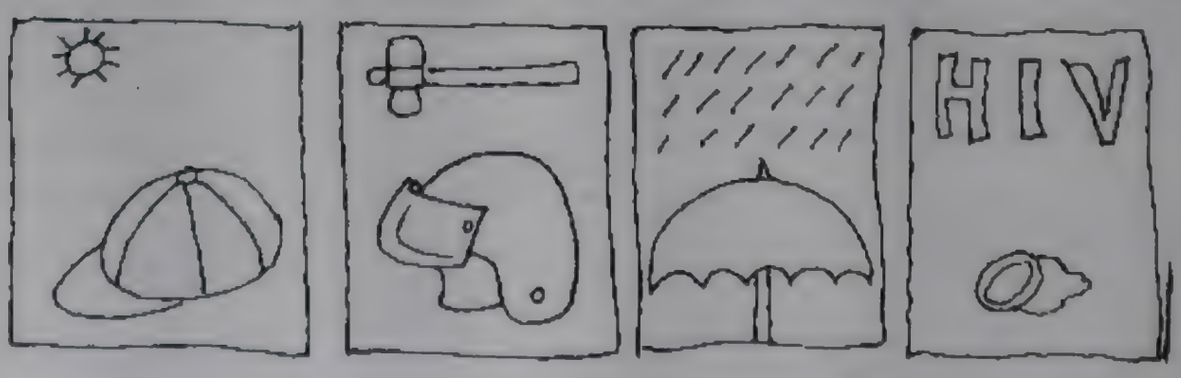
I was curious to go to the PHC and see whether they sterilise the needles. When I went in, I saw the compounder giving injections to many with the same needle. All he did was dip the tip in water and then inject another person. In his other hand, he was holding a cigarette. I watched this for some time.

Then, I stood in the queue myself. When my turn came, I said, 'I'm HIV positive. Will you use the same needle on me, and then on the others?'

He was taken aback. 'Are you an ANM?'

I replied, 'Do your ANMs question you like this?' He said nothing. I told him, 'Before you go on, please throw away your cigarette.'

He stood up and said, 'Madam, whoever you are, please don't complain about me. I have plenty of needles. I'll use them!'



Cancer in Women

The ordinary cells and organs in our body are governed by the controls of a certain ecological order. Our cells are constantly being replaced - as old cells die, new ones grow. Also, each cell has a programme which decides its structure and activity. But cancer cells grow out of control multiplying rapidly, and invading surrounding healthy tissues and organs, gradually spreading to other parts through blood and lymph. All of us have some cancer cells inside. But our natural body resistance is able to cope and to mop them up. Several factors cause a person to lose immunity to cancer, including a wrong diet and pollution of the environment by chemicals and radiation.

Pushpa shared her experience with women who had struggled to survive with cancer.

I did a speculum exam for Krishnamma, a sangha woman. Her cervix looked perforated and deformed. The walls of her upper vagina seemed like they were being eaten up. There were lots of secretions and a terrible smell. I was worried, and I went with her to a doctor friend in Hyderabad. My doubts were confirmed when I saw the report of cancer of the cervix

Krishnamma's family wasn't willing to accept it, so she wasn't taken for treatment. Within a month, she began to bleed, and soon she died.

Cancer of the cervix and ***breast cancer*** make up two thirds of cancers in women. Both of them can be detected early with the help of *breast self-exam*, *vaginal speculum exam* and *pap smear*. If we can detect these cancers early, we can prevent much suffering and many deaths.

Cancers of our reproductive system are *hormone-dependent*. While hormones may not cause these cancers, high hormone levels can aggravate existing cancer cells. Cancers of breast, womb and cervix have been linked with use of hormonal contra-ceptive pills.

Local Women Reflect...

We had shared various supportive and remedial self-help measures with the women of Rapur. But before they parted from us, we explored discriminatory customs, and they were encouraged to take steps to change them. The participants from SPEAK INDIA said they would follow up and give support.

At the end, the women from Rapur gave their impressions of this session.

Most of our fear went away by the way you treated us and made us feel respected. We weren't 'patients' or 'cases'.

We sat with you, and we learned a lot about our problems.

When we saw our yonis through the speculum, we were fascinated to know what is in there - it was really something new!

No doctor ever told us anything, and everything was always a secret.

Many remedies are within our reach - now we can take care of ourselves.

Healing of Gyn-Ecological Disorder

In gyn-ecological healing, medical and surgical treatments have a *limited* role. Yet, allopathic and surgical treatments may sometimes be needed. For referrals, it is important *to find doctors* who will listen and who are sensitive and will respond to women's problems, whom women can trust, and *who will respect the self-help approach.*

The healing of most gyn-ecological disorders can be brought *within reach* through the collective initiatives of women. Women can work out a vision of healing in totality,

engaging with life-stories,
working through relations with men
in our families and communities,
fighting for justice at work-place
ensuring food throughout the year
raising and sharing herbs,
reclaiming, learning, discovering
singing, and dancing -
feeling relaxed and whole.....

Child-Bearing Support

Objectives

- to see how reproductive processes and experiences are medicalised
- to encourage healthy woman-sensitive local and indigenous practices
- to acquire skills to support women through pregnancy, child-birth and afterwards
- to prepare ourselves to work with traditional dais, and strengthen local practices supporting women in child-bearing
- to understand childlessness from a gyn-ecological viewpoint, and to look at adoption as child-bearing

Methodology

Practical Routines:	pregnancy visits child-birth assistance breast-feeding, and after-birth visits
Group Sharing:	harmless and harmful practices
Role-Play:	support during pregnancy, child-birth and after
Pictorial Charts:	pregnancy changes foetal positions normal child-birth process difficult and births milk formation and release sex determination
Self-Help Kit:	aids for supporting child-bearing women

Supporting Women in Child-Bearing

Supporting women in pregnancy, during child-birth and afterwards was an important skill-based part of this training. In addition to the skills themselves, our participants needed to be able to work along with traditional dais in their area. On behalf of their projects, they were also expected to conduct dai-training.

Most in our group had not attended a woman in child-birth. For practical learning and inter-action with village dais, we were glad that we could have this six-day session at the DDS project in Medak District. The project also has a good relationship with the staff at the government hospital at Zaheerabad.

...A Flash-Forward

We relate an experience told by Sathyavati to our group one month after this session. During the training, she learned the basics of how to assist a woman in giving birth. She got excited and grew confident that she could help at child-birth back home. She knew one of her sangha members, Pappamma, was due to give birth. On the evening when Papamma's labour began, Sathyavati went to be with her.

The *dai* Venkatamma came soon after, straight from the fields. When she started to feel Pappamma's belly, Sathyavati suggested she wash her hands. Angrily she replied,

Washing hands causes a difficult birth!

She set about roughly kneading and rubbing Pappamma's belly. Sathyavati intervened again,

Akka, you can cause harm to the baby if you do that.

Venkatamma replied,

One has to shake up the belly to make the head move down. I 've been trained at the government PHC. I know.

Then, Sathyavati felt the woman's belly, and she found the baby's head already deep down in the pelvic hollow. The dai got angry and walked off, shouting,

Since when have you become a 'doctor'?

Before leaving, she told the family that Pappamma is in danger, and that they must go and call the doctor. A local RMP came soon, and he took out a box with a *pitocin injection* to make the 'pains' stronger. Sathyavati tried convincing him that Pappamma was all ready for normal child-birth. She was getting good labour pains, and she didn't *need* an injection! But the RMP ignored her and gave the injection. He took his fee and asked the family members to remove Pappamma to the hospital.

Now that the dai had left the scene, Sathyavati was nervous.

It was my first experience. Since the doctor had come in between, I couldn't easily ask them to let Pappamma stay back. So, I started off with the family to the hospital twenty minutes away. In the cycle rickshaw, Pappamma gave birth. I let the baby fall in my lap, and held onto Papamma with both my arms. As we reached the hospital, the placenta came out - there wasn't much bleeding. I asked the family, 'What should we do?' They said, 'Let's go home.' I was filled with joy and fear at the same time!

Later, Sathyavati went to visit Venkatamma and explained how important it is that they work together.

The Medicalisation of Reproductive Functions

Basically, child-bearing is a *natural* biological process. Aside from being natural, it is also *social*. The way people look at and treat child-bearing moulds the experience of women. The social structuring of child-bearing is different for *traditional rural* and *modern urban* society. Patriarchy, of course, is part of both.

Women have been bearing children without doctors or hospitals for many thousands of years. Today, more and more, child-bearing is being medicalised. In the big cities, *caesarean* cuts are almost routine. But, the creeping roots of medicalisation are spreading beyond the small towns out to the farthest villages. By now, in the rural areas nearly everyone has seen local quack-doctors and ANMs using *pitocin* and *IV glucose* injections. City and small-town clinics promote *ultra-sonography* and *amniocentesis* tests during pregnancy, often to tell the sex of the foetus so females can be aborted.

On one hand, child-bearing is medicalised, but on the other, in the rural areas too few ANMs and trained dais are available to support women around child-birth. According to our participants' own survey, 96% of births take place at home, mostly attended by untrained dais. To bridge the gap, both the government and NGOs undertake dai-training throughout most of our country. In-spite of all these efforts, there has not been much change. Morbidity in pregnancy is reported to be

49% in rural Andhra Pradesh (Status of Women and Children in Andhra Pradesh, UNICEF, 1990).

In view of poor health services in the rural areas, the dai has an important role. Compared to home child-birth, hospital 'delivery' is not always the best alternative. In home births, the infection rate is only 4.9%, while in hospital it is 22.8%.

Dais and Their Practices

Dais, or traditional mid-wives, are often members of the oppressed or *dalit* castes. They are often experienced and skilled. They have successfully coped with difficult situations while attending women in child-birth.

Bayamma explained how she had coped with an amusing but precarious situation

Once, I was faced with a hand peeping out of opening. I was in a fix about what to do, and felt very nervous. I thought for awhile, 'til I had an idea. I lit a match-stick blew it out, and touched the tip to the baby's hand. At once, the baby took its hand back in. After that, I was able to slowly turn the baby, and helped the woman to give birth normally.

Melamma told us how she had handled an unexpected double child-birth.

The baby had been born, and the placenta had also come out. When I started to gently massage the woman's womb through her belly, I realised that there was still something inside it! I was surprised, but I knew it could be another baby. I took a deep breath and relaxed, and assured the woman and her family that we need only wait calmly. Within minutes she got another good pain, and the second baby was born. Everybody was relieved and happy. One baby was a boy and the other a girl.

Since the tradition of *dais* has been weakened, our group felt that we must find ways to work along with them.

There are regional variations in the practices of dais. But there is a common base of belief and practice. Some traditional functions of dais are:

- staying with the woman in labour, reassuring her, seeing that she gets rest and fluids,
- feeling for foetal position and progress,
- massaging, stretching and supporting vulva,
- turning and easing or getting the baby out,
- getting the placenta out,
- revival of the new-born infant when needed,
- tying and cutting the navel cord,
- ritual burial or disposal of placenta,
- massaging and bathing woman and baby, and
- occasionally giving breast-feeding guidance.

In our participants' villages, the dai is usually called only at the last moment, so she attends the birth and cuts the cord. Then, for a week, she gives a daily bath to the woman and child and washes their clothes.

During the actual child-birth and for a number of days afterwards, the woman and baby may be considered 'unclean'. Often, no one else will touch the soiled clothes. The status of dais is worsened by insulting and arrogant attitudes in the dominant medical system.

Some practices of dais are doubtful and full of risk. Even today, dais use a sharp edge of bamboo, a sickle or rusted knife or blade to cut the navel cord. They don't feel that earth on one's hands is unclean or unsafe. They are sometimes too rough about forcing out the placenta. They often believe that colostrum is unhealthy, and say that it should not be given to the baby for the first three days, and that a baby should be given caster-oil for seven days to 'clean it out'.

Although dais' services are needed by communities, they aren't given status or value. Their skills are not updated. They are paid a pittance. How can they be expected to take on more responsibilities?

Our Experiences

I was happy to be pregnant, because at last I would be sent to my mother's house.

I wondered what was happening inside - the baby was moving about, but I couldn't imagine the space...

How could such a large, growing thing come out?

I had fever for three months. Everybody thought I didn't get my periods because of the fever. When they took me to the doctor, I was pregnant .

I had a lot of vomiting - it was very bad. I use to eat tamarind all throughout those days, until my child was born.

When my child was in my stomach, I would eat mud, ash, cow-dung... how I liked the smell of cow-dung!

The smell of bleaching was so soothing. I'd go and sit near the dhobi's house and inhale the essence.

I felt very sick. I wouldn't eat a thing. But I wanted cow-dung cakes. At night, when all were asleep I'd sneak out and eat bits of them. Afterwards, I'd wash my mouth, then I'd go to sleep.

Pregnancy Changes

Pregnancy extends from implantation to birth. Usually, we can estimate the expected date for childbirth by adding nine months and a week to the date of the last menstrual period (LMP). Because of the conditions of rural and poor women - malnutrition and prolonged breast-feeding with irregular ovulation - the LMP is not always a reliable indicator for the time of conception.

Women can tell they are pregnant by observing changes, like

- cravings for special things,
- feeling sick and vomiting, in the morning,
- missed menstrual periods,
- breast enlargement and sensitivity,
- having to pass urine again and again,
- feeling the womb getting bigger,
- feeling heavier and larger, and
- feeling the movements of the foetus.

Changes in the Breasts: our breasts grow, and the *ducts* and *milk-sacs* develop. The skin around the nipples becomes darker.

Growth of the Womb: The womb increases in size and softness. After three months, it can be felt above the pelvic bone. At about five months, it reaches the navel. One can measure with one's fingers. Every four weeks, the height increases by about two fingers, as is shown in the diagram. About two to four weeks before birth, the womb lowers as the head moves down into the pelvis. The cervix is softer in pregnancy. Through the speculum, we see the colour of the cervix changes to a deeper red or almost bluish purple, because more blood comes to the womb.

The Placenta is a temporary organ which functions inside the womb during pregnancy. It brings to the foetus all that is needed from the woman's blood, and sends back waste substances.

The placenta develops during the early and middle part of pregnancy. It grows from the surface of the fertilised egg or embryo where it implants into the womb lining. Near birth, the position of the placenta is usually in the upper or central part of the womb.

The Foetus: The first internal movements can be felt by a women herself around the fourth or fifth month. Beginning from the sixth month, limb movements can be felt with a hand on her belly, and the heart-sounds can be heard through her belly. The woman becomes familiar with the movements, and from this she can tell that things are OK, or whether anything is wrong. The foetus is surrounded by waters, so it moves around a lot until the last month. Then, usually, it turns to a head down position.

Following a Woman through Pregnancy

Because of socio-economic, cultural, and political factors, any woman can be at risk in pregnancy and around childbirth. If we are active in women's sanghas, and we adopt a self-help approach to women's health-work, then we will know ***which women need our special support*** -

- ⇒ who are severely anaemic
- ⇒ who are depressed or anxious
- ⇒ mentally or physically dis-abled women
- ⇒ with bone deformities and stunted stature
- ⇒ with injured, infected and descended womb
- ⇒ who have had bad experiences in earlier pregnancies and child-births
- ⇒ carrying twins or foetus in abnormal positions
- ⇒ with signs of toxaemia, diabetes, and heart and kidney problems.

Modern medical ante-natal care (ANC) is mechanised and impersonal.

Do we really need those inhuman kinds of check-ups? Do they reduce the risks, or do they increase them?

Keeping in mind the precarious health of women, following a woman through pregnancy is essential. Appropriate and regular visits with child-bearing women can help them to stay healthy and comfortable and avoid needless worries and complications. But, we must re-look at *all* the routine procedures - weight, BP, urine and blood tests, regular scans, stress tests, genetic defect testing.

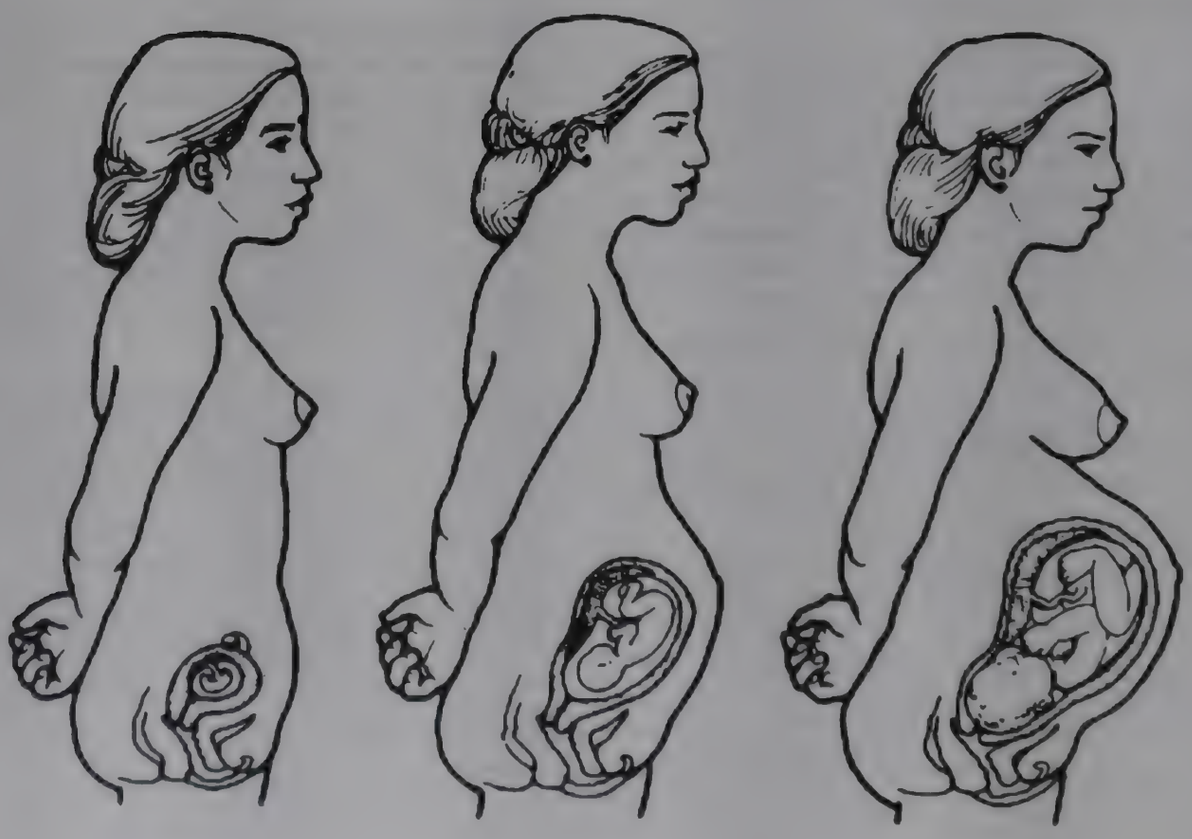
How necessary is each one? Which of them shall we bring into our practice of self-help?

Rural women are not used to any kind of intervention before child-birth.

We never had it before, why should we have it now?

We've had so many children, and everything went on well - if there's no problem, why look for one?

We need to work along with women and dais to build a *new* tradition of self-help support in child-bearing. We want to ensure friendly, woman-controlled and women-centred care.



Care during Pregnancy

Knowing a woman's story, with a focus on her previous child-bearing, is essential. We must always find out whether she has any underlying problem which could get worse.

The *place for visits* is wherever the woman feels 'safe' - at the home of the woman, the dai's home, sangha centre, women's resource centre.

Together you and she may *talk* about how pregnancy happens, and how the foetus grows inside her. You may see towards her getting enough food to take care of *both* herself and the foetus. She may express any fears, especially if it is her first child-birth.

⇒ first visit *(after missing a menstrual period)*	• to consider life-story & risk factors; her overall health, time of conception and expected time of child-birth • to feel her womb and pelvis, confirming a normal (not tubal) pregnancy; to explain conception & pregnancy • if all OK, to give advice on care until next visit, including awareness of problem signs • to make a link with the *dai* from her village

⇒ next visit - *whenever* she feels like having a chat. *If there are risk factors*, or a problem has come up needing exam, *visits should be more often. You can look her up whenever you are in her village.*

⇒ later visit(s) *(at least once in the seventh month)*	• to see her general health • to check the womb height and condition of the foetus • to explain advanced pregnancy and child-birth • to give advice on care, including nipple massage, food and home support, special remedies, and tetanus toxoid • to teach her breathing and pelvic exercises
⇒ another visit *(within the month before child-birth)*	• to continue regular checking, including breasts • to see that she gets the second dose of TT • to listen to her feelings, answer questions, and prepare her for labour and the birth.

Note whether she is worried or depressed, has any handicap or is short; has any swelling of feet or puffiness of face, paleness, breathing difficulty, abnormal pulsations; needs tests, like urine and blood Hb, VDRL, and so on.

Care of the Breasts and Nipples: Applying oil on the nipples and gently pulling them outward stimulates and toughens them. This prevents cracking and soreness.

We discussed how to organise visits with the pregnant women in the sangha's area, and how to get needed tests done from the PHC.

Food during Pregnancy

Problems like anaemia, night blindness and joint pains get aggravated in pregnancy. With the realities in mind, it can be painful trying to advise a woman about her diet. Women do need food to meet the extra demands of pregnancy on one's body. We approached this by focusing on discriminating customs and de-mystifying food taboos.

Foods like brinjal, papaya and drumstick leaves are thought to be hot and to cause miscarriage or bring on labour too early, which is not true. Women are told to eat less for fear of having a big baby and a difficult birth, and that the foetus has to share space in the stomach with food, so it won't grow. If you eat *enough* food, the baby will be healthy, but not big. The women were aware now that the foetus doesn't grow in the stomach, but in the womb. The food eaten doesn't come into direct contact with the womb, but nutrients are carried by the blood to the foetus through the placenta.

Some Discomforts

A woman may experience discomforts because of the changes in the body combined with pre-existing anaemia and malnourishment. These could be *nausea and vomiting, burning in the stomach, dimmed vision at night, feet swelling, back pain, constipation, piles* and so on.

Avoid taking medicines, eat regularly in small quantities, enough foods containing roughage like green leafy vegetables, drink plenty of liquids, avoid spicy food, eat less salt and Take enough rest, and raise your feet if they get swollen.

Serious Conditions in Pregnancy

If you find a woman has any of the following conditions, you must take her to a hospital as soon as possible.

- ***Bleeding**: painful* bleeding in *early* in pregnancy is likely to result in mis-carriage, while bleeding *later* in pregnancy from the site of a low-lying placenta is *painless*.
- ***Severe Anaemia**:* with severe paleness and weakness, puffiness, difficult breathing, fast pulse, and leg swelling.
- ***Toxaemia**:* signs including *swelling* of the feet, hands and face with *headache*, *dizziness* and sometimes *blurred vision*. Sudden *weight gain, high blood pressure,* and *protein in her urine* are other important signs.
- ***Tubal Pregnancy**:* rupture causes agonising pain in lower belly, severe pallor, rising pulse, sweating and cold clammy skin. The woman may or may not have missed a period, or have vaginal bleeding.

In tubal pregnancy, the fertilised egg gets implanted in the tube and grows there. The tube cannot stretch much - it usually bursts within a few weeks with loss of blood inside the belly.

Preparing for Childbirth

See that the place is clean. Ask the woman to *keep ready a* new blade, clean cloth and clothes, a strong thread, soap for washing hands, and a clean vessel for boiling water.

Signs that show Labour is Near: A few days before labour begins, the *baby moves lower* into the pelvis; the woman breathes more easily, but she may pass urine more often because of pressure on her bladder. Just before labour begins, a small *plug of mucus tinged with blood* may come out.

Labour contractions (or 'pains') may start several days before childbirth. At first the contractions are spaced far apart, are few and may not be very strong. But as labour continues, the contractions become stronger, more regular and come sooner.

Waters breaking: The bag that holds the baby in the womb may break with a flood of liquid. Most often, this happens during labour, but sometimes before. Then, labour is likely to start within 12 to 24 hours. The woman must take care to avoid infection, by not inserting anything into the vagina.

Labour and Birth

Labour is a continuous process that includes the birth of the baby and the pushing out of the placenta. We are concerned about supporting a woman's total state of balance as she approaches birth.

Early Labour: The womb begins to contract regularly and strongly, with a *strong pulling and stretching sensation* in the lower belly and vulva.

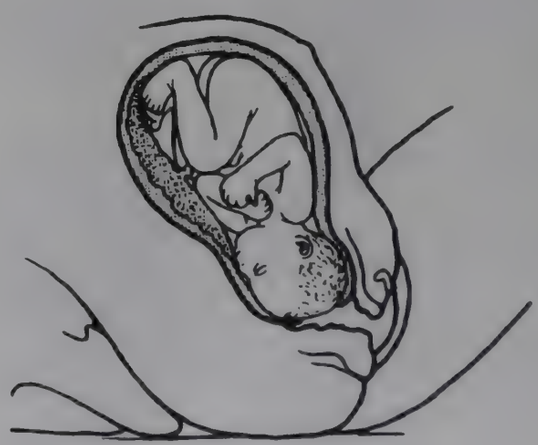
The woman should get some sleep to replenish her energy for active labour later. Going on with one's routine physical work helps the womb to contract and become ready for the birth sooner. The woman needs assurance and support. One must not hurry her. She should not bear down until the foetus moves into the birth canal and the cervix is fully open. Bearing down too early distresses the foetus and makes the woman tired.

Passing urine and moving one's bowels helps labour. This lets the head move downwards. Ask her to drink plenty of liquids and walk around. Help her to relax and take deep breaths during the contractions.

Active Labour: Contractions become strong and more frequent. A woman feels them building *like a wave*, pulling and tightening, spreading throughout the womb, into the back or groin, and then lessening.

In between contractions, she can walk and talk, or let herself relax and sleep. Pass urine regularly. Relaxing deeply between contractions gives energy for the new one, and helps reduce pain.

In rural areas, a common position adopted by women is *squatting* We encouraged this position. It gives the woman a sense of control over what is happening around her.



Signs of Birth Coming Near: You may have *a powerful 'opening up' feeling*. Contractions may come rapidly and become more intense. If she is able to relax she will feel better. The mouth of the womb opens fully. If the bag of waters has not broken, it is likely to break now.

⇒ Now, a woman may need others to help her breathe deeply, and focus her energies.

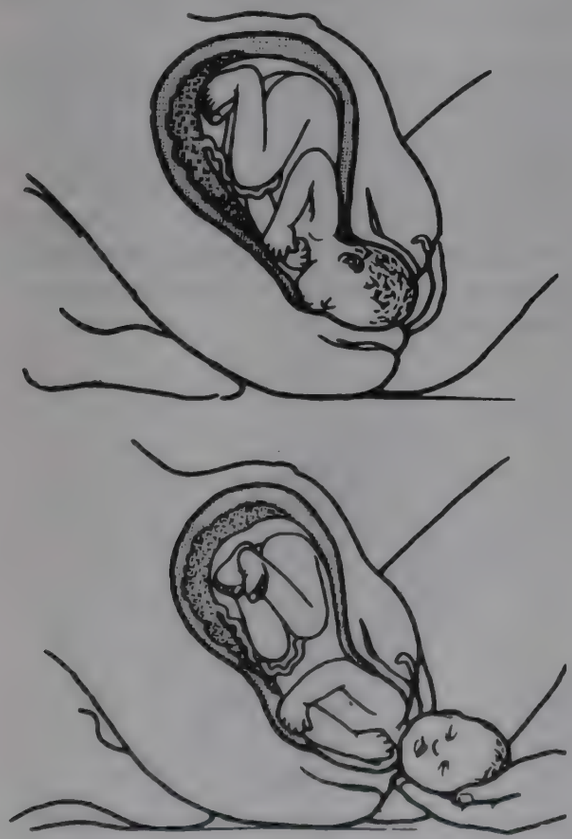
After the womb opens fully, *labour often slows down*, and the contractions may be farther apart; *or labour may speed up* with contractions coming so close together, they feel like one long one. She may hardly have time to take a breath before *'pushing* contractions' begin.

The womb contracts by itself and will push the baby out! Ask the woman to bear down only when she feels the urge. Women's experiences are all different. She may want to howl, moan, shout, grunt... or simply push, or 'breathe' the baby out!

⇒ *Between contractions*, ask her to breathe lightly and not push, while you gently stretch and massage the vulva around the baby's head. Do *not* put fingers inside the vagina to check the level.

⇒ *During a strong contraction*, the top of the baby's head will peek out of the stretched opening. Firmly support the vulva and anus with both hands, so that the opening doesn't stretch too much and tear the skin and flesh.

Usually with a few strong contractions, the baby's head will come through. Do not pull at the baby, but *feel for the cord* around its neck. If the cord is around the neck, see how loose it is. Tell the woman not to push and slowly try slipping the cord over the baby's head. If the cord is tight, tie the cord there itself and cut it and then let the baby be born. During a contraction, first free the above shoulder, and then slowly and gently the lower shoulder and the whole body.



As soon as the baby is born, hold it slanting downwards so that the mucus from the nose and mouth drains out and it breathes freely. Wipe the eyes, nose and mouth. Do not cut the cord yet. Give the baby to the woman upon her belly, or keep the baby down between her legs, being *careful not to pull on the cord*. As you wait for the placenta to come out of the birth passage, see the baby's colour, breathing and movements.

The Placenta Coming Out: Most of the time, the placenta comes out *by itself* within half an hour. But, it may take up to an hour.

Do not pull on the cord. If the placenta is delayed, the following methods will enable the placenta to come out of the womb and upper part of the vagina.

⇒ Try *tickling the back of the woman's throat* with the ends of her hair (the dai's method), and ask her to *bear down hard*.

⇒ *let the baby suck at her breast*, or otherwise stimulate her nipples, to strengthen the contractions.

⇒ use *gentle* circular motion to massage the womb from below upwards (don't push downwards), and slight pressure inwards, with *gentle* cord traction.

Rarely, the placenta does not separate *('retention of placenta')*. It is firmly attached due to certain illnesses or other problems This is dangerous, and the woman must be taken to a hospital.

⇒ After the placenta comes out, open the membranes to check the womb-surface of the placenta and see that it is smooth. After that, ask her to bear down once more, to remove left-over blood-clots.

Cord-Cutting: Cut the cord *after* the placenta comes out. This is usual practice in the villages and there is no harm in waiting. In fact it may be good for the baby not to have the cord cut very soon. The baby gets blood it needs this way. Tie the thread onto the cord one inch from the baby's navel. Use a new blade or boiled scissors to cut the cord. Apply turmeric powder to the cut end. If the cord is around the neck and you have to cut it immediately, then tie the cord in two places and cut in the centre.

Through her belly, with her own hand, show her how you ***massage the womb*** so it gets firm. If the baby has not been given the breast to suck, this may help now.

See her vulva to make sure the bleeding is less, and if there is any tear. Help her wash herself - *warm neem water* is good for this. She may want to dry her vulva over *smoke of burning ajwain seeds and garlic peels*. Any cuts or tears should be dusted with *turmeric powder*.

See that she gets something hot to drink and can rest.

See her again one hour after the birth, to see that the bleeding has not re-started for any reason.

If the Baby does not Breathe, or is Weak: Try the following measures,

⇒ simple rubbing of the back, cleaning the mouth and nose to unblock the air passages, and *stimulate it* with a sprinkle of cold water.

⇒ (dais' traditional method) with the cord attached, *put the placenta into warm water*; dab it rhythmically, massaging the cord towards the baby.

⇒ after clearing the air passages and stimulating the baby, if it still does not breathe, give gentle and small *mouth-to-mouth breaths*.

Care of Woman and Baby after Birth

On the first day, ***the baby*** should be cleaned and checked. The white creamy stuff may be left on the baby for some time - it is protective, and most of it may be absorbed. If the baby is healthy, sometimes the *dai* gives the *first bath* right away. While doing this, she may get it to pass the *first faecal goo* which is dark green and sticky. This proves the anus is not closed. If this doesn't happen, be sure to check the anus, and also the spine, the mouth and palate, the nose and ears, the eyes, the fingers and toes, and the joints, especially the feet and the hips. Is the *baby's colour* a good healthy pink or ruddy? See the baby's basic reflexes - rooting and sucking, grasping and the 'startle' reflex. Observe the breathing and listen to the heart-beat for regularity.

For one week, visit the woman and baby every day. Be sensitive to the mood in her home, and gauge the extent of support she is getting. How does she look? - tired, happy, depressed? How does the baby look? - peaceful and contented, or irritable and cranky?

Feel through ***the woman***'s belly to see that the *womb is returning to its normal size*. Check the woman's *vulva* to see that it is clean and the *after-birth secretions* do not smell bad, any tears are healing, and the bleeding is less day-by-day. Is she bathing and washing her vulva daily with *warm neem-water* or with soap? Is she using clean cloths? How many times does she change the pads?

Check the breasts to see the flow of colostrum or milk. Does it flow easily? Is there any hardening or any pain? Also check the nipples for soreness and cracks. Is the baby sucking often, and strongly, or having any problem?

Remove the coverings of ***the baby***, and check it quickly from head to foot, including the *soft spot* at the top of the head, and the *navel*. Is the cord drying, or is there any redness, secretion or pus? Any skin problem? Any change in colour? Check the eyes, nose, mouth and ears. The infant usually loses some weight during the first week, due to water loss through the skin. But the soft spot will not be sunken, as in loss of water from diarrhoea or vomiting. Is the baby warm enough, or too warm? Is it having a bath every day? Are the bowels moving, and is urine coming often?

Overall, make sure the woman is eating *enough nourishing food* and drinking *fluids*, that she is getting *enough rest*, and that there is *no unattended cause for emotional tension* which might harm her health, reduce her milk-output, and dampen her ability to care for her new-born. Giving ajwain, methi seed and jaggery to eat or to drink after delivery is a good tradition

Breast-Feeding

The baby should be allowed to suck at the breast as soon as possible after birth. The thick straw-coloured liquid from the breast which comes before the milk is called *colostrum*. It is *good* for the baby. Colostrum contains nutrients specially suited for a new-born infant. Also, it contains anti-bodies which protect the baby from infection. If the baby sucks often and strongly at the breast, it increases the woman's milk.

Sometimes breasts may get too full and become heavy and painful. The baby may not be sucking enough, or there may be too much milk. You may need to take out the milk a few times by hand so that the baby can grasp the nipple. Hot fomentation before feeding will usually help within a day. Support the breasts with a cloth sling or a bra. Nursing the baby often helps to prevent the breasts getting too full.

The Woman's Emotions

A woman needs emotional support around childbirth, which she rarely gets. The coming of a new child can disrupt her life. Giving birth itself may be stressful, not knowing what the outcome is. Some women experience depression after childbirth. It may be deeper with repeated births of girl children. Even giving birth to a male child puts un-reasonable and unjust demands on a woman. The elders in the family focus on the son, and blame her for not caring enough. Then, caring for the needs and feelings of her older children presses upon her, too.

With a self-help approach, can we develop adequate support systems for child-bearing women in our communities?

Difficult Births

Most difficult problems may be found out during pregnancy visits, in time for suitable action or referral. But occasionally you will see a woman for the first time in labour itself. Sometimes labour stops or slows down after the waters break. If nothing is very wrong, labour will pick up again after trying simple measures. If labour still doesn't proceed, it could be because of one of the following conditions. If there is time, take the woman to a hospital.

Breech position - the baby's buttocks are downwards instead of the head, and the head is in the top part of the womb. It is difficult to deliver babies in breech presentation, but experienced dais do it. The risk is that the larger after-coming head may get stuck.

If the birth is imminent, the head needs to be flexed by the following technique.

⇒ raise the woman up so the baby's body hangs down

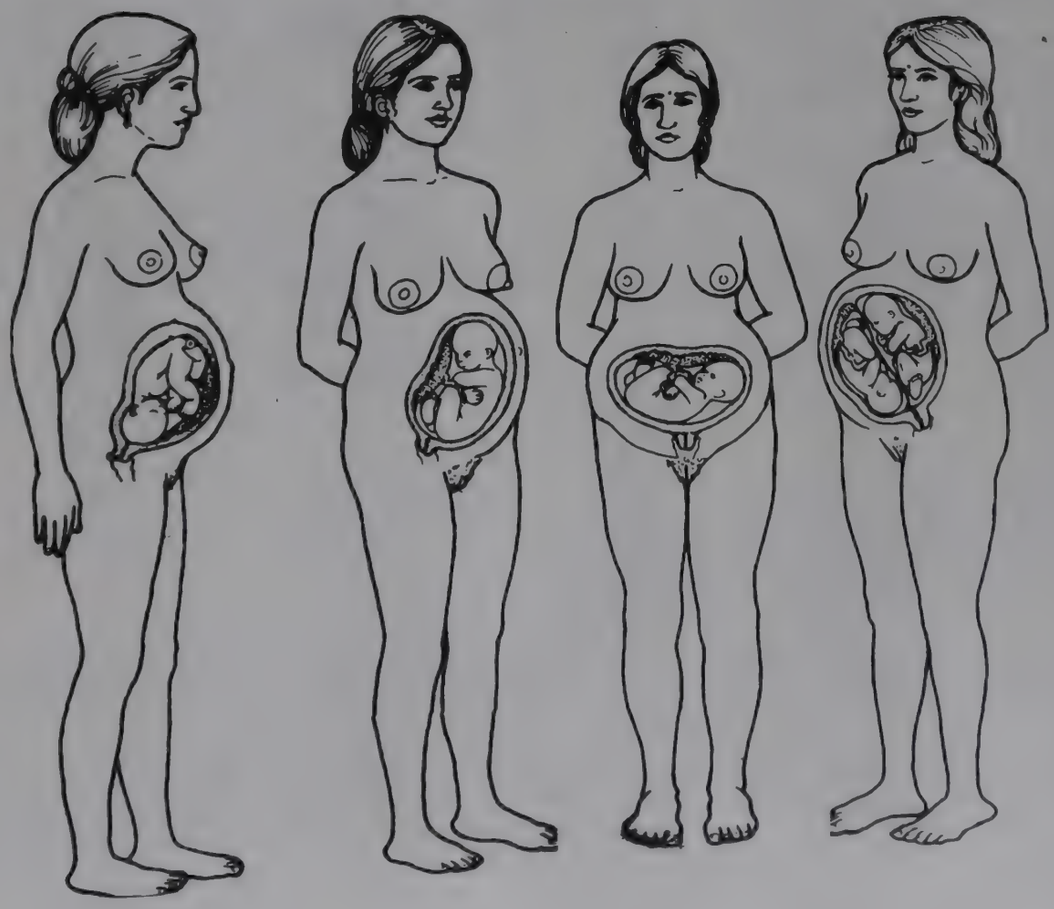
⇒ place a finger inside the baby's mouth, and draw the baby's head towards its chest

Twins - signs are a big belly, lots of limbs, two heads, two foetal heart-sounds, sometimes lots of fluid. Twins are often born pre-maturely and are small, there is usually no obstruction.

Narrow pelvis or large head - In a first childbirth, if you think the woman's hip bones are too small or deformed, or if the baby's head seems too large, it is better to take the woman to a hospital.

Transverse Lie - the baby lies across the belly, making it look wide. The pelvis will feel empty, and the head will be at one side. Normal birth is not possible.

Low-lying placenta or ***placenta previa*** - the placenta is at the cervix and may obstruct the baby from coming down. Besides painless bright red bleeding during pregnancy, one feels the foetus' head high up, and cannot push it down into the pelvis.



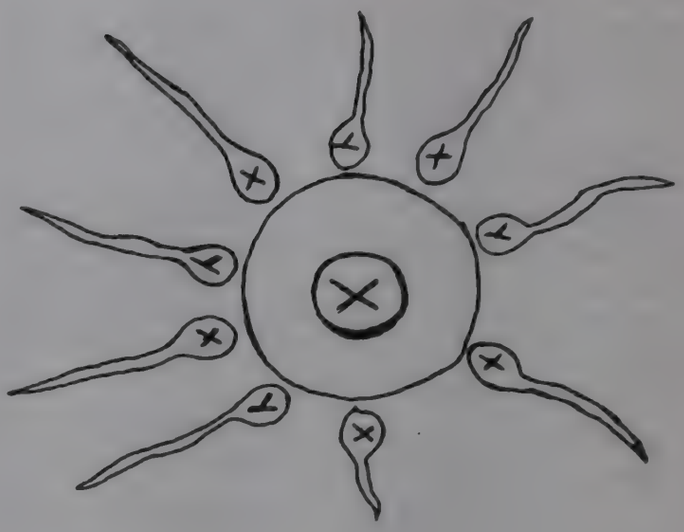
Who, or What, Determines the Sex of a Child?

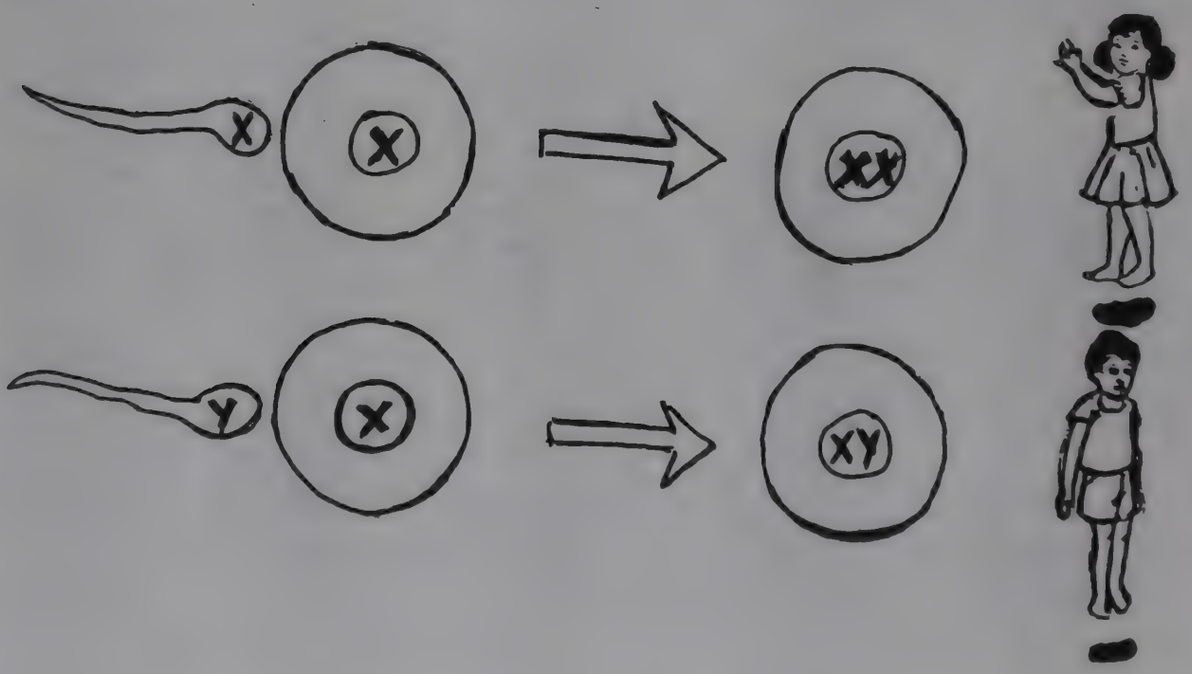
Giving birth to a girl child is not an aberration or an act to be ashamed of. Yet socially many women suffer violence, bigamy, desertion. They are made to believe that they are responsible for giving birth to girl or boy. So, it is important for us to learn how the sex of the child is determined.

At the moment the egg and the sperm unite, it becomes certain whether a female or a male child will be born. This is because of *chromosomes* - some little things inside the egg and the sperm. The chromosomes contain the information for making up a person's body, including one's sex.

The egg and the sperm each carry only one sex-chromosome. The egg always has an X-type chromosome, but *sperms may have either an X or a Y-type chromosome*. So, when an egg and a sperm meet, the combination is either XX or XY. When there is XX, a female will be born, but if it is XY there will be a male.

Thus, a man's X or Y chromosome causes either a girl or a boy to be born.





One has no control over these combinations, and no one can be held responsible.

Although none in our group had herself suffered from the mis-belief about sex-determination, they all knew women who had. They were keen to get back and share their understanding about X and Y sperms.

Childlessness

During a follow-up visit to Dibbupalyam in Ankapalle Mandal, a woman came up to us and confided that she was childless after six years of marriage.

Kusuma felt like an outcast because all were blaming her. She was looked upon with scorn and not allowed at marriages or other celebrations.

We asked Kusuma about her childhood and family story, and details of her menstrual cycle. We also did a physical and bi-manual exam. We could not find anything wrong. Just as we were deciding to call for her husband, in he walked with his mother, both quite agitated. We shared with them what we thought about Kusuma and advised that the husband, Shankar to go for a check-up.

Shankar said he had already had tests, and doctors said everything is alright. He only needed to take some penicillin injections. We asked him to get all the reports and prescriptions. On seeing the test reports we found that Shankar and Kusuma were both VDRL-positive, but only Shankar had been treated. His sperm count, too, was only 7 million (it should be 30 to 60 million) and the sperms were weak and sluggish.

The doctor had not taken the trouble to explain to this couple either the semen analysis or the STI problem, which he thought penicillin would solve.

About fifteen other women in this village told us that they, too, were childless, and that there were many more. It was disturbing for us to see so many women feeling cheated and denied and desperate, most on the brink of desertion if not already single. It was not hard to link up this situation with the prevalent practice of *child marriage* in this area.

We discussed with them the usual causes of childlessness. They are -

- a problem with the man's sperm, the fluid in the man's semen doesn't support the sperms, the man is unable to deposit sperms at the cervix.
- the woman isn't ovulating, her vaginal or cervical secretions are not friendly to sperms, her womb lining is infected and doesn't allow the egg to implant, she may have an undeveloped or divided womb, there may be a blockage of the egg-tubes, or her cervix may be weak.

There may be varied underlying causes, like genetic abnormalities or infections in either partner, environmental toxins, radiation, etc.

Sometimes there is no chance for conception because neither of the partners has enough understanding of intercourse, or knows about the fertile days around ovulation.

Add-Option!

Roughly ten to twenty percent of couples are not able to bear a biological child. The two options forced upon couples are magic or medicalisation. Modern medicine looks at childlessness as a disease and calls it *'infertility'*. New reproductive technologies are touted as a 'cure' and are insulting and damaging to women's bodies. But, doctors never suggest adoption for child-less couples.

We discussed why society gives so much importance to having biological children in marriage. The reasons identified were to carry on the family and to inherit property. But in our society, both of these require a son. So, it is not only important to have a child, but one is supposed to have a male child. Becoming a 'mother' through the bearing, birth and rearing of a biological child is perceived as the ideal. When this doesn't happen, women feel deprived of a great social privilege, and they live in guilt and envy.

True, there can be disorders in men's and women's bodies which make it hard or impossible for them to conceive or bear a child biologically. Often, finding the disorder and healing it enables the couple to have a child. Learning fertility awareness skills also helps many couples to conceive. But some times, for one reason or another, some part of the disorder can't be changed. The couple then has to realise that they won't have a biological child. But it *doesn't mean that they must remain childless*. They can experience parent-hood in a full sense. Adoption of a child is *a positive reproductive choice* that people can make.

Because of society's warped standards of marriage and patriarchy, some women are forced to give up their children for adoption, and they are invisibilised and blamed. They are in *no-choice situations*.

Let's dream for a moment.

Couldn't adoption become a bridge between two women?

One is a victim because she's a mother, and the other a victim because she's not.

4

Phase Two - Follow-Up

We were now coming to the end of the sequence of six-day training sessions. The mood of our group was up-beat, despite missing a few participants who had started with us. The *last six-day session at Hyderabad* was spent in various activities tying up the training and *preparing for the next phase* of follow-up which would focus on work in the project areas.

The collection of *survey* data and tabulation had continued throughout the training. Now we were analysing the total *results of the survey and monitoring*. From this, the participants would prioritise the needs of their areas and plan their further work.

The women took an active part in preparing *the practical self-help kits*, even buying some of the contents from the market. The kit included speculums, gloves, mirror, torch, foeto-scope, scissors, packet of blades, soap, towels, dusting powder and storing containers.

Details of two *women-and-health programmes* were planned, for Anakapalle and Rapur. We spent a lot of effort and time on preparing a health exhibition. As a group, we worked out the themes and content for two cloth scrolls. The first, 'Women and Violence' traced violence right from the time the girl child is conceived. The second scroll was about women's bodies, fertility awareness, menstruation, and gyn-ecological disorders. We composed and taped commentaries and songs. We prepared charts on violence, work, child marriage, food, and herbal medicines.

Then, before departing in the four directions as we had every month for so long, there was hugging, this time no holding back of tears. We assured each-other of meeting again together at the two programmes in the projects.

In the second phase, we made a third visit to each partner project. Apart from this, SVDS and SPEAK INDIA both carried out five-day *women-and-health programmes.* They involved their project teams, our group, and the communities in their areas.

At Anakapalle

SVDS had the first 'women-and-health programme' at Anakapalle. Nageshwari and Sathyavati managed the local arrangements. The remote preparations had started back when our participants had done the initial survey, when women asked them for help with their problems. The sangha women and project team members alike were curious to know what the training was all about.

The programme was scheduled from the 16th to 21st June, 1994. Nageshwari informed the women in the villages, and a personal letter was sent to the sanghas. Women from fifteen villages responded.

Nageshwari and Sathyavati collected medicinal herbs, and prepared *amla* and jaggery 'tonic' and *triphala* powder. They conducted short village trainings to orient women animators and project team members for a more active role.

Many women from surrounding villages, including project staff and animators, attended the official opening. Since official inaugurations are part of NGO culture, we had to bear with it. Later, we realised that it had helped us know what idea the project decision-makers have formed about self-help. Besides, this was an occasion for getting local and district-level recognition of the programme. It also assisted in making known the self-help perspective on women's health.

There were four parts to the programme - health exhibition, life-stories, self-exam, and healing-and-counselling.

Our participants trained the SVDS project staff in taking life stories, and infused the programme with sensitivity and humanness. With knowledge, self-esteem and confidence, they evoked everyone's participation, without any arrogance or competition among themselves.

We took time and listened to the women. We gave them the chance to talk about what worries them most, yet what had seemed so private.

According to the problems they had expressed, we helped them to do the different self-exams. With the help of a mirror, we guided them to insert the speculum themselves, the women looked inside at the ecology of the *yoni* ! After seeing and smelling secretions, they were able to see if there was infection.

The women were open and frank about things that arose out of the exams. Among them were teenage girls. Solutions were not always easy, and counselling took time and energy. Later, they told us,

This was different from being with doctors!

But, reviewing our first day, we were not happy. As time went into the inauguration, there wasn't enough time for education. And the NGO looked at this programme as a 'camp'.

For many women the word 'camp' itself brings horrific memories of government camps, and we had decided not to use the word. But it was difficult to instantly de-school the NGOs, and on our first day even we sometimes felt ourselves being sucked into the camp attitude.

We started our second day on a different note. As women arrived, we began talking with them. We sang songs together. We showed them the charts, asked them what they saw, and helped them find answers to their many questions. The scrolls started off a lot of discussion, especially the one on Women and Violence. In it they saw their story.

Women liked the scroll on the Body, too. They asked a lot of questions. In the herbal medicine charts and demonstrations, they recognised most of the herbs, gathered from their own surroundings - fascinated to think of all these resources within their reach. The older women added to the herbal remedies.

The project teams now tuned into the process. Small groups dispersed into a mango grove, and life-story-taking was more intimate.

It helped the women to reflect deeply about their problems, and how much they had in common with each-other.

Twenty women had come with childlessness, and we asked both partners to come for a check-up. They came next day with their husbands. Most of them had STIs, and men had slips showing they were 'VDRL-positive'. Some women had problems with womb descent, some with irregular menstrual cycles. Nageshwari made notes to work with certain couples later to chart their fertility cycles.

Among the childless women, there were eleven below sixteen who had been married off as girl children. Under-fed, their bodies were stunted and under-developed. In most of them, we found a small and undeveloped womb through bi-manual exam. We took the opportunity to make women aware of the outcome of child marriages, an issue already raised through the scroll on Violence.

The women wanted still more time. They had so many fears and doubts. They had never felt so important and listened to, and so secure in a space like this. They were in no hurry to rush home. After each one's own problem had been heard, they listened to and counselled others.

The women saw us all alike, not preferring to see any one of us in particular. This equal appreciation and respect gave a boost to the sangha members.

Subbamma said,

Women can see our heart, our face, and they know who is for them. I feel very proud today.

Each was advised according to her problem. Simple herbal remedies, how much and how to prepare them, were shown and discussed. Garlic and neem tampons for vaginal insertion were

demonstrated. Pelvic muscle strengthening exercises were practised.

They took everything in. They noticed nothing was kept secret from anyone - everything was in their language, not in english. Before, they had been confused about seeing doctors for their problems - they had visited every kind, right from ordinary ones to orthopaedic surgeons. They had wasted precious money and time on tests and treatments. Each doctor had experimented on them, never explaining.

One hundred and twenty-five women went through the whole process at Anakapalle. Problems that we found are in the Table.

problems found at women-and-health programmes	in 125 women at Anakapalle	in 225 women at Rapur
severe anaemia	20	63
lung tuberculosis	-	10
piles	-	10
acidity	-	13
womb descent (mild)	-	2
(moderate)	-	2
(severe)	3	4
yeast overgrowth	10	20
trichomonas infection	59	52
menstrual problems	24	30
angry cervix	6	20
syphilis ulcer	-	1
genital herpes	-	1
breast lumps	-	2
cancer of cervix	2	-
for pap smear	5	2
childlessness	20	32

Many also had lower back and belly pain. Problems after tubectomy were usual. Most were under-fed and anaemic.

We did our best to discuss food with the local conditions in mind. We showed how to sprout grains to maximise nutrients like vitamins. But, even green gram was twenty-eight rupees a kilo! Gooseberry (*amla*) was locally available, and so we showed them how to make *amla* extract. *Triphala* packets were there at cost price.

The dilemmas at Anakapalle were many.

- We had no answer for anaemia and malnourishment, without addressing the injustice of wages being only ten rupees a day to take care of the entire family. Where do we start?
- Women with severe womb descent and cancer needed surgery immediately. They cannot afford the expense of travel to the government hospital. What about the costs of tests and medicines, too? What do we tell them?

Suvarnamma from Dibbupalyam, aged thirty-five, was upset when she examined herself. There was an ulcerating growth on the cervix, and a foul smell. We found she had cancer. We advised her to go to the government hospital at Vishakapatnam, and mentally prepared her for surgery. She was very upset. She has no means even for the travel.

How do we tackle such situations? Suvarnamma was not the only one - nine others needed immediate care. The animators tried to come up with solutions.

The mahila sangha should loan money. And, we must force the husband to mobilise financial help. We have no other alternatives.

Their helplessness isn't only because they are poor, it's because they are women! Which of them can refuse sex, or force her husband to wear a condom if he's infected?

Indeed, which one of these women will tell her husband,

Sell what you have, so that I can undergo this surgery...?

It would be cheaper for him to let her die and get another wife.

We didn't want to end on such a despondent note. Along with the project staff members - both men and women - together we tried to think of more ways to mobilise funds so the women can get the care they have a *right* to.

Let us form a common sangha-level fund for women who need special care. We can appeal in newspapers. Also, there are sources for donations in town, like Rotary and Lions Clubs...

Our male team members must go to men in the communities and make them aware of their responsibilities in regard to women's health.

Women must organise to demand changes at the Government hospital.

Sanghas are being organised. But, under the New Economic Policy, all government welfare support services are being cut back. The dilemmas persist.

At Rapur

Between the 16th to 21st July, 1994, we had our second women-and-health programme at SPEAK INDIA Two days each were spent in two remote clusters of villages around Govanpalli and Devadampalli, and one day was kept for Rapur town.

Navneetha had conveyed 'self-help' to women as an effort to stand on their own feet and make decisions. They had grasped from her that 'health' is not only absence of illness but also of violence, discrimination, inequality and injustices.

With our first experience at Anakapalle behind us, we were better prepared. Subbamma was especially enthusiastic, as she was surrounded by women from her area. She explained the scrolls in their own dialect and was able to spark off a lively discussion. They identified most with the Violence scroll, but they got very involved with the Body scroll, too.

For the first time, they understood how we get periods and that it is not polluting. Relief came over their faces when they realised that they are not to be held responsible for giving birth to a girl-child, as they only have 'X' seed-cells.

The women discussed the herbal medicines and food items in the exhibits with enthusiasm, since they were all locally available and affordable. Here again, Subbamma communicated in her own style, holding the interest of the group.

Women team members from SPEAK INDIA helped us in taking life-stories. Breast and speculum self-exams were done, and then belly and bi-manual exams, too.

There were eighteen pregnant women, and the group got experience interacting with them and examining them.

Men and children turned up along with the women. Men were led aside to a separate space and advised according to their problems. We saw to the problems of the children, too. On the whole, the health of the tribal men, women and children was very poor. They looked wasted from hard labour and lack of food. Most had soreness at the angles of the mouth, dull eyes and discoloured hair and were anaemic.

Among two hundred and twenty-five women, the problems we found at Rapur are listed alongside Anakapalle's. As far as childlessness is concerned, we found that STIs and under-developed reproductive parts were the main underlying problems .

Simple herbal remedies, exercises and change in food and other relevant habits were advised for healing. Wherever needed we had demonstrations. The people in this area were poorer, and we were even more frustrated about how to advise them than in Anakapalle! Navneetha and Subbamma agreed to look for women-friendly doctors in Nellore who would receive referrals and do pap smear tests.

Our last-day was to be in Rapur town. On the evening before, we received a message from the project leader not to have education input during the programme, as most of the women attending would be from the Muslim community.

They are not used to talking about their bodies and problems.

He wanted us only to check them and give them 'treatment'. This would defeat the whole purpose of the programme. We discussed it with the self-help group, and decided not to do the programme if we could not carry out the whole process. The women could go to any doctor in Rapur.

It is wrong to stereotype and deprive the women like this!

We told the project leader about our decision. He didn't like it at all. But he had no alternative, and he asked us to carry on. To everyone's utter surprise, *eighty* muslim women turned up the next morning!

They participated actively in the whole process, spoke openly, did self-exams and passed on the message to others who came later in the evening. Myths and stereotypes about this minority group of women were given a stiff blow.

Women's Resource Centre - a Reality...

SVDS made a beginning in October 1994, supporting Nageshwari and Sathyavati to start a Women's Resource Centre in Thummapalla. Many women came to the opening.

This Centre doesn't belong to SVDS - it is ours! At last, we have a place to meet and talk, to grasp issues important to us, and to know all about ourselves.

At first, the Centre opened from 10 in the morning until 2 in the after-noon. On Saturday market days, it was open 'til late evening. Now the timings are being adjusted to keep the centre open everyday late in the evenings, so that women returning from work can visit them.

Our visit to the Thumapalla Women's Resource Centre this year was heartening.

The centre is an independent house with one fairly large room with a sit-out and a spacious terrace, and a bath-room on the outside. There is a board which reads 'Aadvalu Salaha Kendra'. Sathyavati works there full-time, while Nageshwari drops in practically every other day and works full-time on Saturdays.

Both have made the centre comfortable. In the last six months, eighty-five women have visited the centre with various issues.

Shardamma approached the PHC for an MTP. She was forced to accept the condition of undergoing tubectomy. Both operations were done, and she was discharged. On the third day, she developed a severe infection, with bloating of her belly. Back at the PHC, she was refused admission. Her family then took her to a private nursing home, where she was able to recover.

Nageshwari and Sathyavati took up this issue. They started negotiations with the PHC doctor to get compensation from him for all her expenses.

Devi and Lachhamma had seen many doctors in town, and came to the centre to show their slips. They both had heavy and painful periods for many months. The doctors had advised removal of the womb as the only 'cure' for both women.

Sathyavati first examined them, and among other advices, she suggested they try out touch-me-not decoction for three months before deciding. Using pictures, she also explained removal of the womb and the possible effects it could have. It is now three months and they are both feeling better.

Raniamma, Kamala and Kaushalyabai were referred for pap-smear tests, because they had heavy foul-smelling secretions with inflamed angry-looking cervixes. The tests of each showed early cancer-like changes. They are all being treated. Kamala is now having radiation therapy.

The centre is also used for cluster meetings where women from the Mandal villages come together.

One day, the doctor from the PHC met Sathyavati and asked her, *What do you do in your centre?*

In reply she said,

What the PHC does not do, we do!

5

Evaluation, Dilemmas and Hopes

Evaluation

The entire evaluation process extended right through the training and follow-up phases, and still continues. It has been at different levels - personal, in the group, by the project partners and teams, by ASMITA and other involved friends. It has involved a continuous critique of the training process and content. Not all of this evaluation was planned, and some of it was difficult and filled with tension. At the end of the twenty months, we had a special closing session, where reflection and evaluation was in focus.

In the Group

During the training sequence, every month we reflected upon our experiences before we parted. We would try to over-come misunderstandings and tensions. It was not easy for twenty women - the participants, our centre helpers and us two - to live together for twenty-four hours, six days of every month. Only when each one had been able to say something, would we close.

One of our challenges lay in the mixed character of the group. Contrasts between project staff women and sangha women existed, mainly because of the formal education and the middle-class exposure.

For the 'educated' project staff women it was an up-hill task to 'de-school' themselves from their formal learning. Also, it meant over-coming a deep-rooted attitude of aloofness and impatience with so-called 'illiterate' persons like the sangha women. The change in Nageshwari's personality was dramatic. She had undergone nursing (ANM) training, but - as she said herself - it was doing her own self-exam which brought on her transformation into a caring and confident self-help worker, treating other women no different from her-self.

It was a job for the two of us to keep the group together, especially in the first few months. We constantly had to see that competition and narrow self-interest did not creep in and split the group. We all tried hard to learn being gentle and sensitive when criticising each-other, and even when self-criticising. The participants had their very personal evaluation of the two of us.

You were one among us, you never held yourselves apart. There was no hierarchy - only a spirit of equality, trust and respect for each-other. You were like friends, concerned and caring, knowing our moods,
our health problems, and the problems back home.

They appreciated our independence and autonomy, our rising to occasions.

Even when resource persons didn't arrive, you were ready to take over. You got together all the materials and visuals.

They noticed we didn't mince our words.

Whenever you were angry, you had the courage to express it straight out - you didn't carry it on.

Our stands were clear - with them, and with their project leaders. Yes, we stood by the participants. When we felt injustice was done to them, we took risks for their sake. And we tried not to show partiality between them, either.

Despite Telugu not being our mother tongue, we always spoke it. Sometimes when expressing something technical got difficult for us, we just kept on trying until all understood!

The reports of each training session, written by participants, helped us to see how much they had grasped. The women were really good at this, and developed the skill.

The flat where we had our centre was decent and gave us privacy, and our working conditions were convenient and comfortable. ASMITA'S support went a long way. We were freed from thinking of the physical details as Mani and Meera took care of them. Our group experienced a deep feeling of well-being and freedom in this space!

At Project Level

Despite keeping up contact about the training through letters and visits, and regularly informing the project partners about progress and content developments, we had some communication problems during the training phase. Two project partners could not fully comprehend the self-help approach and principles.

One had already got a community health programme plan sanctioned, and he had to submit financial and implementation reports to his funders. He had visualised a twenty-bedded hospital with doctors, nurses, ANMs and clinics. While our participants were still under training, they were under pressure to start work and show results. It created tensions. We asked him to wait until the training was over. We were confident that our participants would be capable of starting women's resource centres, dealing effectively with health problems, without medical personnel. We would use doctors only for referrals, outside the program.

At the sangha and village level, the participants' sharing had to be selective, as others had not gone through the same process. But one of the project partners was keen that her participants replicate the sessions immediately. So they began using the pictorial charts of the body to explain at sangha meetings. When men heard of the tabooed topics being shared with their wives, they stopped women from attending the sangha meetings.

Also, a participant's growing assertiveness and self-confidence was a problem for the project leader. The staff participant had to leave the project, and because of that, the two sangha participants were not allowed to continue the training, either.

We wanted to visit the organisation and discuss the matter, but ASMITA said they would visit and clarify with these project partners - this didn't take place, however.

The Closing Session of the Training

In November 1994, we had a two-day closing session to the training programme. Besides ourselves and participants, all four of the project partners came - even the one who had withdrawn from the training. Indira Jena helped us co-ordinate. Vasanth, Volga and Meera from ASMITA, Uma from DDS and Mira Sadgopal were there, too.

To begin, Indira situated self-help training historically within the women's movement. She recalled the Self-Help principles, and why these particular projects were selected. She was happy that three participants would be joining SPANDANA to help strengthen its 'women and health forum'.

The Participants' Sharing: The participants shared their experiences of how the training had helped them as persons, at work, in the community, and in dealing with medical professionals.

Nageshwari reflected,

At the end of this training I can confidently say that I have been de-schooled from my conventional health training. I have learned to observe, chart, and analyse my fertility cycle. I have started sharing this knowledge with my team members and the animators. Now, I am working closely with twenty childless couples. I have started training dais. I can find out and heal some of women's disorders. I have also started sex education for girls and boys in two municipal schools.

Sathyavati and I have started a Women's Resource Centre, where women and teen-age girls visit us. We give only herbal medicines. The project has set aside three acres for medicinal plants. I get a lot of support from my project. I am also involved in SPANDANA and I share 'self-help' with them.

I am a changed person. Now, I see the importance of collective functioning and can work well with others. The many opportunities of the training increased my confidence to talk with medical personnel, government officials and with other men. I have become more sensitive and concerned about women.

In my body, I often feel drained, but my spirits are high.

Then ***Subbamma*** said,

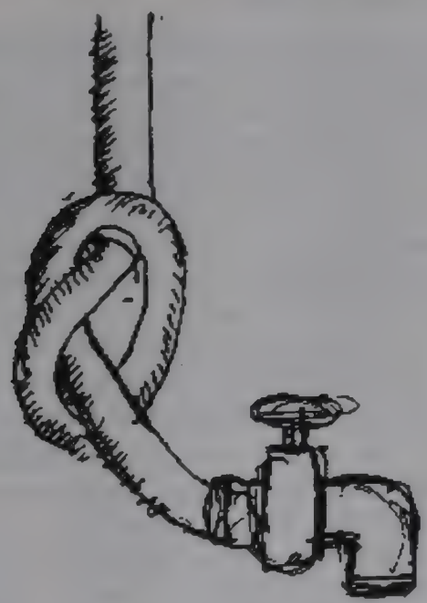
I came to this training because in my remote village there are no health facilities. Even though I can barely read, whatever I have learned is fresh in my memory - I began to read and write only in the training. Self-help exam and healing have been my greatest interests, because in my place a lot of women suffer from white discharges and menstrual problems. In my village men, too, suffer a lot, and they are coming to me with problems.

The other day one man came with difficulty passing urine. I needed to examine him, but he was feeling too shy. In order to make him feel comfortable, I said,

I will need to examine your genital parts. Just imagine me to be a man,

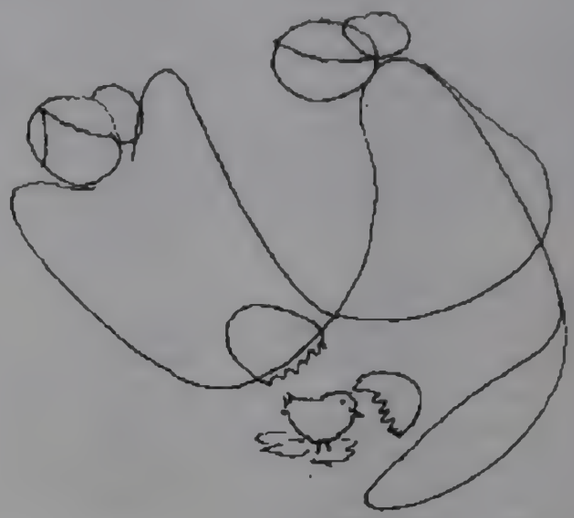
After some moments of hesitation, he allowed me to check him. Then, I gave him a glass of herbal decoction, and asked him to walk around to loosen up his muscles. Within ten minutes, he passed a whole lot of urine with force like a water-pump!

I have learned how to assist in childbirth, making sure of cleanliness, and when I should refer women to the hospital. Now, I am working in three villages.



Nagamma had been discontinued from the training by her project leader at the end of the first year. We were happy to see her - one of our most promising participants. Whatever she had learned she still remembered so well. The training has helped her explain to women of her sangha about superstitious beliefs that affect their health. She is confident dialoguing with the PHC staff.

One day, I went with a pregnant woman to the PHC who was in labour and having some problems. But, the ANM just left her in the labour room and went off for lunch. She was getting severe pains and I could see the baby's head. I didn't know what to do. I helped with her child-birth and waited for the placenta to come out. The ANM returned and shouted at me. I replied, since she wasn't around, I had just helped her. After all, Akka, I too am trained. I hadn't done anything wrong!



My sangha is doing well. Women come to me with all kinds of problems. I am so sorry I couldn't finish along with the others and take the kit home.

Hearing the other participants sharing their experience of the course she felt cheated for not having been allowed to continue. In front of all, she confronted her project leader.

See what you have done! I have been the loser - I told you I would travel alone by bus to Hyderabad, even if Lakshmi couldn't come.

Listening to Nagamma's recollection of the course, her project leader was surprised that even after ten months she remembered so much.

Pushpa said,

From this training I have gained the skills to be a 'self-help trainer'. I am now conducting self-help trainings on my own for our forty health workers. They had requested self-help training back in 1992. I was part of Shodini's collective then. Attending this training has increased my confidence.

My personal relationships have changed. I do not feel threatened by my colleagues anymore. I am beginning to appreciate myself, too. With a supportive team at DDS, I will be able to start a women's resource centre and reach out more into the community.

Vasantha, reflected,

This training has changed my whole personality. It has made me confident and enhanced my self-esteem. I have got more clarity now on various issues, especially women's subordination, the politics of population control, reproductive rights, and body politics. I have learned to become assertive and take clear positions. Sabala and Kranti have been among us as equals, I have learned a lot from them. Fertility awareness has been helpful to me. Men should also get this kind of training. I look at self- help as a movement.

Navneetha shared,

I have come to understand my body - now I feel close to it. Herbal medicine is effective, available and simple to prepare. But, I am having a problem convincing women and my project, as they are so dependent on allopathic drugs. Because of my visits to the PHC and questioning the staff, the women get better treatment.

After our two-day session at Rapur, I did follow up the women, and I've been able to deal with their problems. Subbamma and I are conducting dai-training, emphasising cleanliness during child-birth. Also, I've shared fertility awareness among my project team members.

I've not been able to plan or start a self-help programme, as my project leader is not convinced. My team members are not able to understand, either.

Ten participants were able to complete the training. We had started with sixteen. During the training period,

2 sangha participants we asked to discontinue because of their inability to adjust with the demands of the training,

1 sangha participant discontinued on her own for personal reasons, and

1 staff and 2 sangha members were discontinued by their project leader.

Gains of the Training

The inter-linked aims of the training had been:

- strengthening the self-esteem and confidence of women,
- exposing the class, caste and gender biases in the medical system,
- regaining control over our bodies, labour and property,
- learning how to function collectively and form networks, and
- pressing for public accountability to the concerns of women.

We summarised what we see as the achievements. The training has influenced *all facets of our lives*, bringing out latent resources and strengths within all of us.

At Personal Level: The participants did gain confidence and self-esteem, and a positive self-image as women. Having grown assertive and self-determining, they are no longer willing to be taken for granted. Growing clarity on issues concerning women has made them articulate. They have respect for their bodies, and now they look at menstruation positively. They have got skills in reporting and training others, and some have even learned to read and write.

In the Family: They now make efforts to change family attitudes, questioning the sexual division of labour, and getting male members to share in household work. They are able to convince their partners to use condoms, and to occasionally say no to sex. They question discrimination in food, health care, education and other opportunities, and try to get equal attention for girl children - one has post-poned her own daughter's marriage. When beaten or abused themselves, they have even hit back. They are slowly changing stereotypes of mothers-in-law and daughters-in-law, too.

In Community: They regularly share information with sangha members, and have re-activated some *mahila sanghas*. They are training dais, assisting in child-birth, and accompanying women to PHCs. They use self-help exams to help women see their problems and encourage use of herbal remedies. Two herbal gardens are being developed. They have organised women-and-health programmes and started a women's resource centre.

Relating with Medical Personnel: They ask for clarification from doctors and demand prescrip-

tions, insist that the ANM visits the village regularly and that needles at the PHC are sterilised before use. They have courage to say 'no' to family planning targets. They are building rapport with women-sensitive doctors.

In the Project: Within their project teams, they are confident to conduct training and to question and debate the planning of health programmes. They have made efforts to build team unity, especially among women staff.

Net-Working: They net-work through SPANDANA to build up a women's health forum. Inter-project co-operation in training activities have begun.

Opening 'Women's Spaces': We had planned that a women's resource centre would be started in each of the four project areas by the end of the training programme.

Both project leaders and our participants have taken time to understand this concept. The projects had limitations of outlook, priorities and funds, because of which the participants faced obstacles. Some project leaders tended to be formal and to resist new ideas.

It is creditable that SVDS made a beginning in October 1994, by allowing and supporting Nageshwari and Sathyavati to start the Women's Resource Centre in Thummapalla.

Project Partners' Reflections

The project partners now talked of their feelings about the training - expressing their doubts and questions, asking for clarifications. Parvathamma from ARIDS, Bukkapatnam began.

I don't know what went wrong with my staff. Every time Lakshmi returned from the training, I felt there was a growing distance between her and the other team members. Was I wrong in my selection? Was I in too much of a hurry to ask them to replicate the training? Was this a wrong strategy?

The problem was so bad, that the village men asked us to close the sangha. My staff felt that Lakshmi should leave, and I had to send her away. I know this training is different, and I feel bad now that we have missed this opportunity.

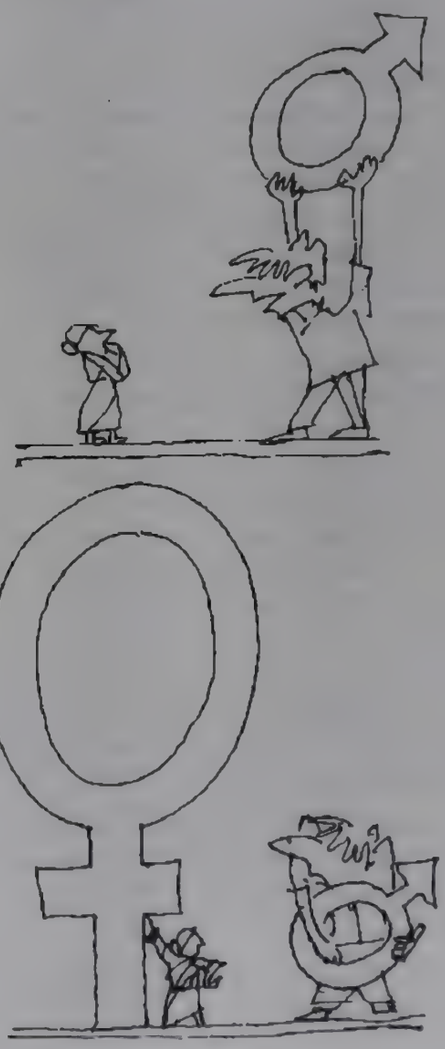
Only today, I have understood the real concept of 'self-help'. A meeting like this could have been held at the end of the first year, where we could have worked out our misunderstandings.

Shameer from SPEAK INDIA, Rapur, spoke next.

What Parvathamma said is my experience, also. Before this, I was planning a health programme, with doctors, nurses, clinics, etc. After meeting Sabala and Kranti and hearing about the self-help training, I felt it would be good to send our women, and then start the programme.

For the first three months everything was alright. My staff shared about the training. After that, there was no sharing, no reporting. Then I had to force them to give a report. Also, their seriousness about work went down.

There was very bold behaviour - you would get answers like, 'It's my body. I can do what I want with it!' Men in my organisation took advantage of this - I said to myself, these women must have got this out of the training.. From the time of the training there was tension in my organisation. The course participants didn't mix with the rest of the staff. A month after the self-help training, Ravalamma beat her husband with a chappal. Is this what is taught?



He felt that self-help 'encourages' women to beat up their husbands. He had not given a thought to all the beating and violent abuse Ravalamma had taken all these years. The group didn't support his point of view, and instead pushed him to reflect on the violence done to women everyday. At this, he fell silent.

In this context, Uma Maheshwari commented,

When someone is sent for training, one must realise that others will feel left out. Hence, extra effort must be made by all to hold the team together.

Jogi Naidu of SVDS Ankapalle then said,

To me, the vision of self help training was clear. I was prepared for problems, as the process is radical. I allowed the participants freedom to work according to their experiences in the training. And today I am glad, because Nageshwari has developed her own leadership, and takes responsibility for the programme.

Women I do not know. So, when women handle women, I don't interfere!

Vasanth Kannabiran commented,

'Self-help' is a new programme, a new ideology. We do not have enough awareness about it. We have not deeply understood the principles of self-help. We do discuss varied topics which may be controversial or radical. Assertiveness in the participants is a logical outcome. This may not have been acceptable to project leaders.

We will face problems like this whenever we talk of our subordination, our politics, our rights and controls.

We also need to consider the situation we are in, and then apply new principles that we learn. We have to question ourselves - are we strong enough to take responsibility for our actions? We talk of our 'rights', but we stop at individual rights, forgetting collective-community-women's rights.

Sexuality and relationships cannot change overnight, just by one training. It may sometimes be acceptable in society to have these relationships, but they need not be openly spoken of.

Training is a gradual process, and the trained persons need to integrate themselves into the team. But, there has to be a effort from the other side, also.

Any knowledge has to be applied to our personal lives. But, in our enthusiasm we may make mistakes. We have to reflect on problems which we can foresee. We could have established more opportunities to dialogue with project partners as the training was progressing, and more co-ordination among project partners, participants, facilitators and team members.

Mira Sadgopal added,

In self-help training, we must not forget learning the limits which cannot yet be crossed in a patriarchal society. We must protect the spaces we create, even as we expand them, and as we link them with others everywhere.

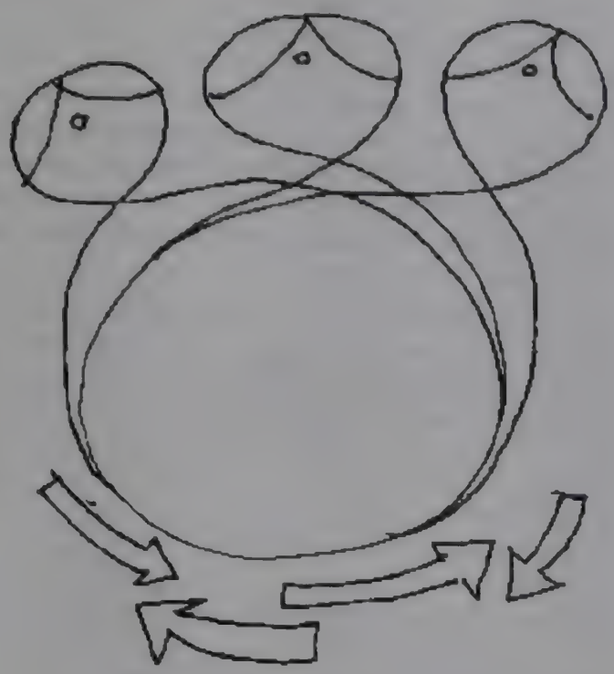
She also said,

For me, this training effort has been inspiring - it is revolutionary for us. When I was asked to do the session on Fertility Awareness, I immediately agreed, because I felt it was important. This training has been a path-breaker.

In retrospect, although we felt the lack of support from project partners at times during the training, we could ultimately talk out the differences and come to some understanding by the end of the closing session.

We have been inspired by the lives and experiences of our women. To us, it was an ideal group. Their trust in allowing us to enter their personal spaces has, once again, strengthened our conviction in sister-hood. Although they had no exposure to the theoretical discourses of feminism, they were open and ready to grasp the values and principles of feminist self-help. The training had some trying moments. It was their support and their interest in the training which kept us both going, determined not to give up. Each one is very precious to us and an unforgettable part of our lives.

The training, as such, was yet another unique experience. In this training, we focused on aspects of women's health which we had not delved into so deeply before. We were able to really probe into the way gender links with caste and class discrimination to influence women's health. And, in the process of sharing self-help practice, we became sensitive to our own bodies, and gained respect for this aspect of our-selves.



Dilemmas.....

Along with the achievements, we faced a lot of difficulties and unresolved dilemmas.

- Women's health is inseparable from *right to livelihood*. Privatising social support services under the government's new economic policy hits poor labouring women the most. How do we integrate this reality into the self-help training, to counsel women, and to better their social and economic status?

- We develop skills to reach out, *not to alienate* ourselves from the community. But, newer needs and pressures bear down on health workers in the field. For example, when childless couples are referred for tests, the technical reports come back in english. Frustrated when they could not explain them to the couples, our participants asked for more technical in-puts. This may draw us into the dominant health system. Where do we draw the limits in self-help?

- In this training, we have given importance to validating women's traditions and herbal remedies. But we really don't know what chances these have with the dominant health system, and problems of rising STIs and so on.

- Women's resource centres are not alternatives to Primary Health Centres. Rather, they are forces *to demand health system changes* which meet women's needs. How do we preserve this character of our centre 'spaces', and resist taking over functions of PHCs?

- Though *safe abortion facilities* were an urgent and desperate need of women, in view of the risks, we decided not to provide the skills. How shall we see that this need is urgently addressed?

- When *women became assertive*, it created problems. They faced a constant dilemma to find space for themselves in the projects and their communities, without appearing to threaten others and without compromising.

- In spite of all our efforts to convey the *self-help approach* to the project partners, some have not been able to understand it. Hence, it has been difficult for some of the participants to work.

- Demands were made on some of the participants to replicate the training every month. This included sensitive topics and in absence of a *self-help process* at the project level, it created misunderstanding and tensions.

- Talking openly about their bodies and simple facts of life gave women courage to resist sexual oppression, but it sometimes back-fired. What strategies can we adopt for protecting ourselves and *keeping spaces open* for expression and exploration?

- Poor and lower caste men are oppressed by both upper-caste and upper-class men and women. To change unequal power relationships, men also need to be conscientised. Yet, we have not been able to *reach out to men* inspite of repeated requests by the projects.

- Project women were often quicker to grasp technical concepts, did more reading, and asked for more information and clarification. During these moments, the sangha women tended to feel left out. How can we give more visibility and scope to the *strengths of sangha women*, so that they don't get marginalised?

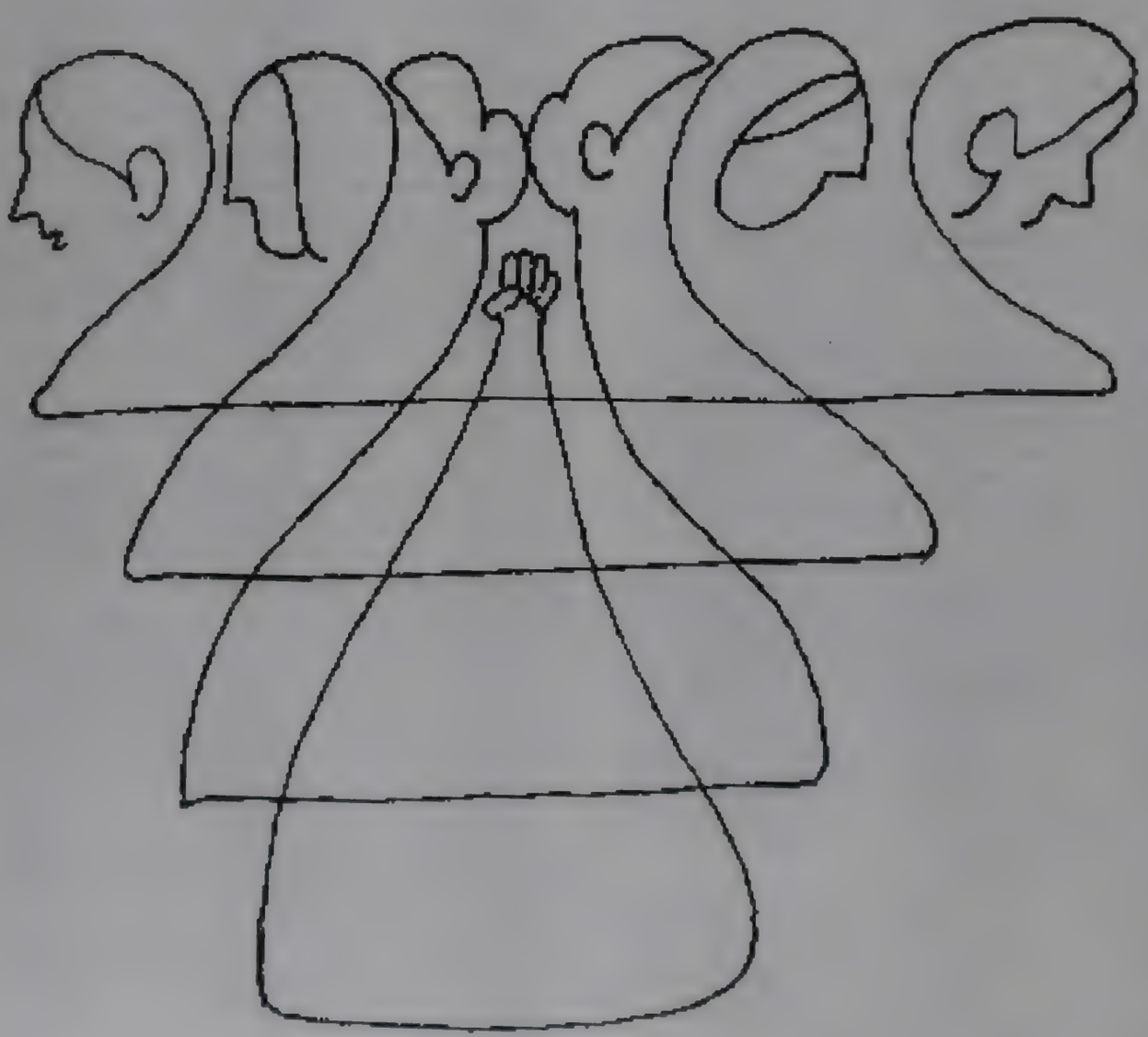
- In spite of trying to look at self-help training *in a holistic way*, we could not go deep enough into areas like legal perceptions of women's bodies, women's work, food, emotional health, environmental degradation, migration and communalism, and so on.

And Hopes.....

We hope this book will assist health activists to plan self-help trainings and start self-help groups in local sanghas every-where, that net-work at a broader level, too. We wish all who read these pages will enrich what we have written by their questioning and creativity.

Starting women's resource centres is one way of reaching out to women. Here, we may create spaces to share issues of concern and to work out alternatives. Our efforts are not to take over the government's responsibilities. In fact, they are to help us demand basic needs and women-centred health services, against the current trend of privatisation - and to extend these demands to include women's access to education, employment, shelter and property rights, and so on. Here, women will be empowered to press for freedom from abuse and violence.

There is much work to do. Self-help is relatively new within the women's movement in our country. It has a crucial role to play in women gaining control, personally and politically.



Editor's Epi-Log

The bigness of the task of making this book was something none of us three had imagined - we thought it would take 'a month'! We also had no clear idea of some of the 'places' we would land up in, and the extent to which the writing-editing task would challenge - and eventually evolve - our friendship.

I live in Maharashtra, not Andhra Pradesh. My window into this training programme was facilitating the session on Fertility Awareness in June 1993, as a resource person. It was a thrilling experience. Never have I, before or since, come into a group of women who were so prepared. Through the previous sessions, they had really got deeply acquainted with themselves as women in society and with their own living bodies.

Not knowing Telugu, I usually spoke in Hindi, which was translated and interpreted to the group by either Sabala or Sathyavati. I suppose, I used a lot of body language, too.

When it came time for the closing session of the training, I made a special effort to reach Hyderabad and join in. There, I was able to meet members of ASMITA and the directors of the four NGO projects, as well as a number of the participants again. The whole session was in Telugu, of course. Despite being the only one who didn't know the language, I felt happy without very much translation. Mainly, I was there 'in body', whole-heartedly to support this important work, knowing that meanwhile there had been challenges and some problems, some still unresolved, and others perhaps still ahead.

Then, a few months later, I met Sabala and Kranti again, at the Medico Friend Circle annual meet at Wardha. They told me they were writing up their experiences of the training, and gave me the draft to go through. My window into their programme was opening wider. I said, *I'll be your editor!* In the process of writing, naturally, a few insights occurred to us, and some things fell into place in ways we had not thought of before.

Sabala and I have both had formal schooling in the medical system, she as a nurse and I as a doctor. No matter how off-beat we may have become, again and again we are surprised by remnants of our strict medical conditioning - the words and phrases we un-thinkingly use, the way we categorise, numericalise, compartmentalise, the way we have been trained to reduce...

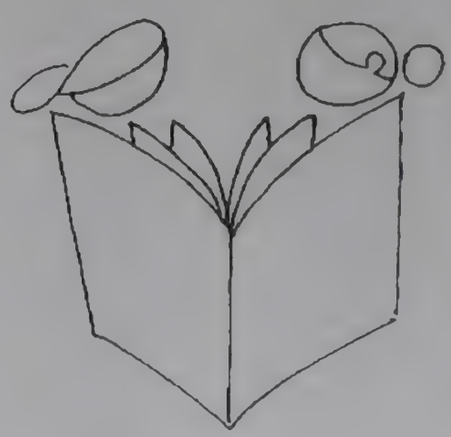
One day, the idea of 'gyn-ecology' as *the whole balance of women's health* struck us, and it grew. More than once, I thought (as an editor), are we forcing an idea upon the participants' experience - an idea they never had? But, I think you will have seen from their own words, our fancy words aside, that it was they - particularly the non-literate sangha women - who believed this all the time. It has taken *us* so-called 'learned' ones longer to come to it.

Sabala has always been faithful and persistent with the social critiquing process, and had war-like determination against the class-and-male structured system - *Never let them get the best of us!*

Kranti's bark has been sharper than her bite. Of the three of us, she has consistently spoken from the women participants side, from their perspective, and forced us to 'de-school'. Often, at one point or another when we were stuck for words to make a link, or to make something click, Kranti would slip into a trance-like state, and one or more of the participant women would begin to speak through her!

Our friend Sanjay Pawar assisted us as an artist. With perception and subtle symbolism, he has succeeded in reflecting the experiences and insights which we have put down in words.

Dinanath Manohar has been yet another member of our team. His role has been crucial, seeing the book through lay-out and graphics processing and getting it set up for the printers.



Post Script

Initially, when we set out on the path of making a book, we thought of printing only 200 copies - enough for our known friends and contacts. But seeing all the effort that went into it and as the complete process of writing unfolded, we then thought of 500 but finally gathered courage to go for 1000 copies. In the span of one year, positive responses poured in from many sides, and the thousand copies have come to an end. Hence, we came in for printing a second edition of 2000 copies.

In the past one year, many friends have been supportive in writing book reviews and distributing the book. Several have also posed some questions. Indeed, some of these concerns had already been reflected in the training, but not in much detail. When reading or using *Na Shariram Nadhi*, we would like our readers to reflect further on these.

Firstly, there is the question of the appropriateness of 'self help' in a country like India where the majority have little access to even basic health care facilities. As Sumati Nair pointed out, *'Two concepts widely contested by feminists and health groups internationally figure prominently in this book - one, that self help as a "tool" is more appropriate for a rich country... and two, the notion of ownership of one's body, or that "my body is mine".'*

Second is the question of integration of various health care systems, as raised by Roopashri Sinha in her review in *Radical Journal of Health*, and dealt with only cursorily by us in the first edition.

Third is another question raised by Roopashri - *'... whether there could have been a greater exploration of the generally known male code of conduct in the section on male body politics. Myths like, it's unacceptable for a male to be a virgin, boys earn their manhood by sexual conquest, men don't talk about sex - they just do it, intercourse is the only real sex, the penis has a mind of its own - once aroused it can't be controlled, and so on - such myths could have been dealt with.*

These questions and other issues have been taken up in our current SADAPHULI programme with MASUM activists in Purandar Taluka of Pune District, Maharashtra, who are experiencing a similar kind of self-help process. The women have themselves chosen 'Sadaphuli' (meaning 'always in bloom', or the periwinkle flower) as a name which conveys their group's self-help perspective. The training phase of this programme will finish in December 1996.

In the short space of time since the first edition of *Na Shariram Nadhi* was printed, we have noticed something peculiar. The term 'self-help' seems to have caught on in all sorts of likely and unlikely places - from management and entrepreneur groups, thrift or credit collectives, to mental health support groups, de-addiction programmes, and so on. We feel that self-help needs to be understood in the immediate political context everytime, and does not become just a fashionable 'buzz-word'. The meaning of self-help, particularly in the arena of health work, should always stay distinct, fresh and healing like the *sadaphuli* flower.

Our References

Politics of Health, and Population

Rakku's Story, by Sheila Zurbrigg

Taking Sides, by Sathyamala, Nirmala and Nalini, New Delhi

We and our Fertility, by Swatija, Chayanika and Kamaxi, Bombay

Something Like a War film by Deepa Dhanraj, Bangalore

Bangladesh Drug Policy, slide series prepared by CDC, Hyderabad

WomanTalk: Contraception. Safety and Our Health, Saheli, New Delhi

Body Politics and Beyond

Body Parts Cut-Out Puzzle, Eklavya, Bhopal

Sharir ki Jankari, by WDP *Sathins*, Ajmer, Rajasthan, published by Kali Press, New Delhi

Beyond Illness, by Swatija Manorama and Chayanika Shah, Bombay

New View of a Woman's Body, by the Federation of Feminist Health Centres, USA

What's Happening to My Body? - Book for Girls, by Lynda Madaras

Fertility Awareness

Mucus Observation Booklet, Kishore Bharati, Hoshangabad, MP

Natural Family Planning in Pictures, by J. Menezes

The Fertility Awareness Workbook, by Barbara Kass-Annese and Hal Danzer

A Manual of Natural Family Planning, by A. Flynn and M. Brooks

Billings Atlas of the Ovulation Method, by E. Billings, J. Billings and M. Catarinich

Fertility Factsheets, by Suzannah Doyle, Fertility Awareness Services, Oregon, USA

Self-Help and Self-Exam

How to Stay Out of a Gynecologist's Office, by the Federation of Feminist Women's Health Centres, USA

Medicines at our Door Step, video-film prepared by Deccan Development Society, Hyderabad

Touch-Me, Touch-Me-Not (in press), by the SHODHINI Colllective, Kali Publications, Delhi

Gyn-Ecological Disorder and Healing

Natural Healing in Gynecology, by Rina Nissim

Our Bodies, Ourselves, by the Boston Women's Health Book Collective, USA

Women, STDs , HIV and AIDS, report of a national workshop, by Abha Bhaiya and Ratna Kapur

Child-Bearing Support

Child-Birth Picture Book, Chetna, Ahmedabad

Our Bodies, Ourselves, as above

Where there is No Doctor, by David Werner, adapted by Sathyamala, VHAI, New Delhi

Technical illustrations taken or modified from -

Our Bodies Ourselves, What's Happening to My Body?, New View of a Woman's Body, How to Stay Out of a Gynecologist's Office, IDT Training Course in Women's Health (Modules 3 & 4), Child-Birth Picture Book, Natural Family Planning in Pictures, Fertility Awareness Workbook, Fertility Awareness Services, and Karen Haydock -

with Thanks !

This book portrays the empowering process of a self-help training experience in women's health. It documents women's collective development of skills in analytical understanding, life-story taking, self-exam, healing and counselling. It deals with issues that adversely affect women's health such as class, caste and gender oppression in family and society, medicalisation of health, coercive and women targeting policies of the government and social stereotyping. The 'body' finds its rightful place in the personal and political framework. The book is also a friendly and practical guide for seeking alternatives.

- Sabala & Kranti

Nā Shariram Nādhi -

'My body is mine' is a dignified yet humble proclamation, not meant to demonstrate individualism, or imperialist control of brain over body. The body once considered a seat of helplessness and shame becomes a source of pride and pleasure.

Sabala and Kranti along with the participants have documented a real feminist treat for all of us in the women's movement, who are involved in the area of health, reproduction and sexuality.

The process of self-realisation through 'self-exam' is gentle, non-competitive and allows each woman the space to work out what is possible (or not possible) in her own life.

The book delves into the precious and inimitable recesses of each woman's mind and at the same time links their experiences into a common thread. At a wider level, the book links women's health to class and caste issues, questioning inequity as well as patriarchy.

Astutely, the book records inter-personal dynamics, and the repercussions of the training in the lives of women when they walk outside the charmed circle of the self-help training. The authors record the 'successes' and 'failures' in a candid and honest fashion.

The form and the content of the book are pleasing and liberating.

- Manisha Gupte
Medico Friend Circle, India